

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

MARVIN NATION, (AIS # 141669)

*

Plaintiff,

*

V.

*

2:06-cv-693-ID

WILLIE AMBERS, ET AL.

*

Defendants.

*

SPECIAL REPORT OF DEFENDANT MICHAEL E. ROBBINS, M.D.

COMES NOW the Defendant, Michael E. Robbins, M.D. in response to this Honorable Court's Order and presents the following Special Report with regard to this matter:

I. INTRODUCTION

The Plaintiff, Marvin Nation (AIS # 141669) is an inmate who was confined at Kilby Correctional Facility located in Montgomery, Alabama at all times relevant to his complaint against this Defendant. On August 7, 2006, Mr. Nation filed a Complaint against Michael E. Robbins, M.D., the Medical Director for Kilby Correctional Facility, alleging that he failed to provide him with appropriate medical treatment subsequent to being involved in an automobile accident on September 21, 2006. (See Complaint). The Plaintiff demands an unspecified amount in compensation for pain and suffering. (Id.)

As directed, the Defendant has undertaken a review of Plaintiff Nation's claims to determine the facts and circumstances relevant thereto. At this time, the Defendant is submitting this Special Report, which is supported by a Certified Copy of Plaintiff

Nation's medical records (attached hereto as Exhibit "A"), the Affidavit of Michael E. Robbins, M.D. (attached hereto as Exhibit "B") and the Affidavit of Linda Lawrence, R.N., H.S.A. (attached hereto as Exhibit "C"). These evidentiary materials demonstrate that Plaintiff Nation has been provided appropriate medical treatment for his complaints at all times, and that the allegations in his Complaint are without merit.

II. NARRATIVE SUMMARY OF FACTS

At all pertinent times, Marvin Nation (AIS # 141669) was incarcerated as an inmate at Kilby Correctional Facility. (See Exhibits "A" & "B"). Nation has been seen and evaluated by Kilby's medical or nursing staff, and has been referred to an appropriate care provider and given appropriate care, each time he has registered any health complaints at Kilby. (Id.)

Mr. Nation has made a complaint in this matter that the Defendant failed to provide him with appropriate medical treatment following an automobile accident on September 21, 2004. (See Complaint). The Plaintiff's allegations are untrue, however, as the Defendant has acted appropriately in treating and evaluating this inmate at all times. (See Exhibits "A" & "B").

Mr. Nation was involved in an automobile accident on September 21, 2004 while working with a road crew while incarcerated at Elmore County Correctional Facility. (See Complaint and Exhibits "A" & "B"). Mr. Nation was transferred to Kilby Correctional Facility on September 26, 2004 following his discharge from Baptist Medical Center East where he had undergone an Open Reduction Internal Fixation (O.R.I.F.) procedure by Richard A. Kean, M.D. to set a left zygomatic maxillary complex (ZMC) fracture as well as left maxillary alveolar segment fracture (which was performed

on September 24, 2004). (Id.) Mr. Nation was housed at Kilby until October 5, 2004 when he was transferred. (Id.)

Dr. Robbins first evaluated Mr. Nation on September 26, 2004 after he was returned from surgery. (Id.) At that time Dr. Robbins noted that he was suffering from post-operative pain, but, otherwise was in no acute distress. (Id.) His jaws were wired together subsequent to surgery. (Id.) He displayed some facial bruising as well as a healing abrasion on his lower left leg. (Id.) He was clinically stable. (Id.) Dr. Robbins subsequently admitted Mr. Nation to Kilby's infirmary for post-surgical care. (Id.)

Pursuant to Dr. Kean's post-operative orders, Mr. Nation was prescribed narcotic pain relievers including Vicoden and Hydrocodone Elixir. (Id.) He was also prescribed Amoxicillin, an antibiotic. (Id.) To facilitate eating, Mr. Nation was placed on a soft food diet. (Id.) He was allowed oral saline rinses as needed. (Id.)

Mr. Nation received regular nursing evaluation while admitted to Kilby's infirmary from September 26, 2004 through October 5, 2004. (Id.) Dr. Robbins personally evaluated Mr. Nation on September 28th, September 29th, October 1st, and October 5th, 2004. (Id.) Mr. Nation's condition remained stable and his plan of treatment was maintained. (Id.) Mr. Nation was transferred to Dr. Kean for follow-up evaluation on September 29, 2004 and again on the morning of October 6, 2004 when he was transferred from Kilby and out of Dr. Robbins' care. (Id.)

It is Dr. Robbins' understanding that Mr. Nation contends he was not provided appropriate post-operative evaluation and/or treatment at Kilby. (See Complaint). However, all of Mr. Nation's medical conditions and complaints have been evaluated and treated in a timely and appropriate fashion. (See Exhibits "A" & "B"). Mr. Nation has

been seen and evaluated by the medical or nursing staff, and he has been referred to an appropriate care provider and given appropriate care, each time he has registered any health complaints at Kilby Correctional Facility. (Id.)

At all times, the Defendant has exercised the same degree of care, skill, and diligence as other similarly situated health care providers would have exercised under the same or similar circumstances. (Id.) In other words, the appropriate standard of care has been adhered to at all times in providing medical care, evaluation, and treatment to this inmate. (Id.)

At no time has the Defendant denied Mr. Nation any needed medical treatment, nor has he ever acted with deliberate indifference to any serious medical need of Mr. Nation. (Id.) At all times, Mr. Nation's medical complaints and conditions have been addressed as promptly as possible under the circumstances. (Id.)

III. DEFENSES

The Defendant asserts the following defenses to the Plaintiff's claims:

1. The Defendant denies each and every material allegation contained in the Plaintiff's Complaint and demands strict proof thereof.
2. The Defendant pleads not guilty to the charges in the Plaintiff's Complaint
3. The Plaintiff's Complaint, fails to state a claim against the Defendant for which relief can be granted.
4. The Defendant affirmatively denies any and all alleged claims by the Plaintiff.
5. The Plaintiff is not entitled to any relief requested in the Complaint.

6. The Defendant pleads the defense of qualified immunity and avers that the actions taken by the Defendant were reasonable and in good faith with reference to clearly established law at the time of the incidents complained of by the Plaintiff.

7. The Defendant is entitled to qualified immunity and it is clear from the face of the Complaint, that the Plaintiff has not alleged specific facts indicating that the Defendant has violated any clearly established constitutional right.

8. The Defendant cannot be held liable on the basis of respondeat superior, agency, or vicarious liability theories.

9. The Plaintiff is not entitled to any relief under 42 U.S.C. § 1983.

10. The allegations contained in the Plaintiff's Complaint, against the Defendant sued in his individual capacity, fails to comply with the heightened specificity requirement of Rule 8 in § 1983 cases against persons sued in their individual capacities. See Oladeinde v. City of Birmingham, 963 F.2d 1481, 1485 (11th Cir. 1992); Arnold v. Board of Educ. Of Escambia County, 880 F.2d 305, 309 (11th Cir. 1989).

11. The Defendant pleads all applicable immunities, including, but not limited to qualified, absolute, discretionary function immunity, and state agent immunity.

12. The Defendant avers that he was at all times acting under color of state law and, therefore, he is entitled to substantive immunity under the law of the State of Alabama.

13. The Defendant pleads the general issue.

14. This Court lacks subject matter jurisdiction due to the fact that even if the Plaintiff's allegations should be proven, the allegations against the Defendant would

amount to mere negligence which is not recognized as a deprivation of the Plaintiff's constitutional rights. See Rogers v. Evans, 792 F.2d 1052 (11th Cir. 1986).

15. The Plaintiff's claims against the Defendant in his official capacity are barred by the Eleventh Amendment to the United States Constitution.

16. Alabama law provides tort and other remedies for the allegations made by the Plaintiff herein and such remedies are constitutionally adequate.

17. The Defendant pleads the defense that at all times in treating Plaintiff he exercised the same degree of care, skill, and diligence as other medical providers would have exercised under similar circumstances and that at no time did he act toward the Plaintiff with deliberate indifference to a serious medical need.

18. The Defendant pleads the affirmative defense that the Plaintiff's Complaint fails to contain a detailed specification and factual description of the acts and omissions alleged to render him liable to the Plaintiff as required by § 6-5-551 of the Ala. Code (1993).

19. The Defendant pleads the affirmative defenses of contributory negligence and assumption of the risk.

20. The Defendant pleads the affirmative defense that Plaintiff's damages, if any, were the result of an independent, efficient, and/or intervening cause.

21. The Defendant pleads the affirmative defense that she is not responsible for the policies and procedures of the Alabama Department of Corrections.

22. The Defendant pleads the affirmative defense that the Plaintiff has failed to mitigate his own damages.

23. The Defendant pleads the affirmative defense that he is not guilty of any conduct which would justify the imposition of punitive damages against him and that any such award would violate the United States Constitution.

24. The Defendant adopts and asserts all defenses set forth in the Alabama Medical Liability Act § 6-5-481, et seq., and § 6-5-542, et seq.

25. The Plaintiff has failed to exhaust his administrative remedies as mandated by the Prison Litigation Reform Act amendment to 42 U.S.C. § 1997e(a). The Plaintiff has failed to pursue the administrative remedies available to him. See Cruz v. Jordan, 80 F. Supp. 2d 109 (S.D. N.Y. 1999) (claims concerning Defendant's deliberate indifference to a medical need is an action "with respect to prison conditions" and is thus governed by exhaustion requirement).

26. The Prison Litigation Reform Act amendment to 42 U.S.C. § 1997(e)(c) mandates the dismissal of Plaintiff's claims herein as this action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks money damages from the Defendant who is entitled to immunity.

27. The Plaintiff's claims are barred by the Prison Litigation Reform Act of 1995, 42 U.S.C. §1997(e).

28. The Plaintiff has failed to comply with 28 U.S.C. § 1915 with respect to the requirements and limitations inmates must follow in filing in forma pauperis actions in federal court.

29. Pursuant to 28 U.S.C. § 1915 A, this Court is requested to screen and dismiss this case, as soon as possible, either before or after docketing, as this case is frivolous or malicious, fails to state a claim upon which relief may be granted, or seeks

money damages from the Defendant who is a state officer entitled to immunity as provided for in 42 U.S.C. § 1997 (e)(c).

30. The Defendant asserts that the Plaintiff's Complaint is frivolous and filed in bad faith solely for the purpose of harassment and intimidation and requests this Court pursuant to 42 U.S.C. § 1988 to award this Defendant reasonable attorney's fees and costs incurred in the defense of this case.

31. The Plaintiff's claims are moot because the events which underlie the controversy have been resolved. See Marie v. Nickels, 70 F., Supp. 2d 1252 (D. Kan. 1999).

IV. ARGUMENT

A. The Plaintiff has failed to prove that the Defendant acted with deliberative indifference to any serious medical need.

A court may dismiss a complaint for failure to state a claim if it is clear that no relief could be granted under any set of facts that could be proven consistent with the allegations in the complaint. Romero v. City of Clanton, 220 F. Supp. 2d 1313, 1315 (M.D. Ala., 2002), (citing, Hishon v. King & Spalding, 467 U.S. 69, 73, (1984). "Procedures exist, including Federal Rule of Civil Procedure 7(a), or Rule 12(e), whereby the trial court may "protect the substance of qualified immunity," Shows v. Morgan, 40 F. Supp. 2d 1345, 1358 (M.D. Ala., 1999). A careful review of Nation's medical records reveals that Nation has been given appropriate medical treatment at all times. (See Exhibits "A" & "B"). All of the allegations contained within Nation's Complaint are either inconsistent with his medical records, or are claims for which no relief may be granted. (Id.) Therefore, Nation's claims against the Defendant are due to be dismissed.

In order to state a cognizable claim under the Eighth Amendment, Nation must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. See Estelle v. Gamble, 429 U.S. 97, 106 (U.S. 1976); McElligott v. Foley, 182 F.3d 1248, 1254 (11th Cir. 1999); Palermo v. Corr. Med. Servs., 148 F. Supp. 2d 1340, 1342 (S.D. Fla. 2001). In order to prevail, Nation must allege and prove that he suffered from a serious medical need, that the Defendant was deliberately indifferent to his needs, and that he suffered harm due to deliberate indifference. See Marsh v. Butler County, 268 F.3d 1014, 1058 (11th Cir. 2001) and Palermo, 148 F. Supp. 2d at 1342. “Neither inadvertent failure to provide adequate medical care nor a physician's negligence in diagnosing or treating a medical condition states a valid claim of medical mistreatment under the Eighth Amendment.” Id. (citations omitted).

Not every claim by a prisoner that medical treatment has been inadequate states an Eighth Amendment violation. Alleged negligent conduct with regard to inmates' serious medical conditions does not rise to the level of a constitutional violation. Alleged medical malpractice does not become a constitutional violation merely because the alleged victim is a prisoner. See Estelle, 429 U.S. at 106, McElligott, 182 F.3d at 1254, Hill, 40 F.3d 1176, 1186 (11th Cir. 1994), Palermo, 148 F. Supp. 2d at 1342. Further, a mere difference of opinion between an inmate and the physician as to treatment and diagnosis cannot give rise to a cause of action under the Eighth Amendment. Estelle, 429 U.S. at 106-108.

The Defendant may only be liable if he had knowledge of Nation's medical condition, Hill, 40 F. 3d at 1191, and acted intentionally or recklessly to deny or delay access to his care, or to interfere with treatment once prescribed. Estelle, 429 U.S. at 104-

105. Obviously, Nation cannot carry his burden. The evidence submitted with this Special Report clearly shows that the Defendant did not act intentionally or recklessly to deny or delay medical care, or to interfere with any treatment which was prescribed or directed. The evidence demonstrates, to the contrary, that appropriate standards of care were followed at all times. (*Id.*) These facts clearly disprove any claim that the Defendant acted intentionally or recklessly to deny treatment or care.

The Defendant is, further, entitled to qualified immunity from all claims asserted by Nation in this action. There is no argument that the Defendant was not acting within the scope of his discretionary authority. See Eubanks v. Gerwen, 40 F. 3d 1157, 1160 (11th Cir. 1994); see also Jordan v. Doe, 38 F. 3d 1559, 1566 (11th Cir. 1994). Because the Defendant has demonstrated that they were acting within the scope of his discretionary authority, the burden shifts to Nation to show that the Defendant violated clearly established law based upon objective standards. Eubanks, 40 F. 3d at 1160. The Eleventh Circuit requires that before the Defendant's actions can be said to have violated clearly established constitutional rights, Nation must show that the right allegedly violated was clearly established in a fact-specific, particularized sense. Edwards v. Gilbert, 867 F.2d 1271, 1273 (11th Cir. 1989), aff'd in pertinent part, rev'd in part on other grounds, sub nom., Edwards v. Okaloosa County, 5 F. 3d 1431 (11th Cir. 1989).

The Eleventh Circuit further requires that the inquiry be fact specific, and that officials will be immune from suit if the law with respect to their actions was unclear at the time the cause of action arose, or if a reasonable person could have believed that their actions were lawful in light of clearly established law and information possessed by the individual. See Brescher v. Von Stein, 904 F.2d 572, 579 (11th Cir. 1990) (quoting,

Anderson v. Creighton, 483 U.S. 635, 640, (U. S. 1987)). The question that must be asked is whether the state of the law in 2006 gave the Defendant fair warning that the alleged treatment of Nation was unconstitutional. Hope v. Pelzer, 536 U.S. 730, 741 (U.S. 2002).

Therefore, to defeat summary judgment, Nation must be able to point to cases with “materially similar” facts, within the Eleventh Circuit, that would alert the Defendant to the fact that its practice or policy violates his constitutional rights. See Hansen v. Soldenwagner, 19 F.3d 573, 576 (11th Cir. 1994). In order for qualified immunity to be defeated, preexisting law must “dictate, that is truly compel (not just suggest or allow or raise a question about), the conclusion for every like-situated, reasonable government agent that what the defendant is doing violates federal law in the circumstances.” Lassiter v. Alabama A & M Univ., Bd. of Trustees, 28 F. 3d 1146, 1151 (11th Cir. 1994). The Defendant submits that there is no case law from the United States Supreme Court, the Eleventh Circuit Court of Appeals, or District Courts sitting within the Eleventh Circuit showing that, under the facts of this case, it was clearly established that these alleged actions violated Nation’s constitutional rights. All of Nation’s medical needs have been addressed or treated. (See Exhibits “A” & “B”). The Defendant has provided Nation with appropriate medical care at all times and he has received appropriate nursing care as indicated for treatment of his condition.

B. The Plaintiff failed to exhaust his administrative remedies prior to filing suit in violation of the Prison Litigation Reform Act (PLRA).

Congress enacted the Prison Litigation Reform Act of 1995 (PLRA), 110 Stat. 1321-71, as amended, 42 U.S.C. § 1997e et seq., in 1996 in the wake of a sharp rise in prisoner litigation in the federal courts. See, e.g., Alexander v. Hawk, 159 F.3d 1321, 1324-1325 (CA11 1998) (citing statistics).¹ The PLRA was enacted in attempts to eliminate unwarranted federal-court interference with the administration of prisons, and thus, to "afford corrections officials time and opportunity to address complaints internally before allowing the initiation of a federal case." Nussle, 534 U.S., at 525, 122 S. Ct. 983, 152 L. Ed. 2d 12. See also Booth, 532 U.S., at 739, 121 S. Ct. 1819, 149 L. Ed. 2d 958. The PLRA was also designed to "reduce the quantity and improve the quality of prisoner suits." Nussle, supra, at 524, 122 S. Ct. 983, 152 L. Ed. 2d 12.

A centerpiece of the PLRA's effort "to reduce the quantity . . . of prisoner suits" is an "invigorated" exhaustion provision. See § 1997e(a), and Porter v. Nussle, 534 U.S. 516, 524, 122 S. Ct. 983, 152 L. Ed. 2d 12 (2002).² Specifically, the PLRA provides that prisoners may not file suit in Federal court for complaints regarding prison conditions unless they have first fully extinguished all administrative remedies available. Specifically,

No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative

¹ The PLRA contains a variety of provisions designed to bring inmate litigation under control. See, e.g., § 1997e(c) (requiring district courts to weed out prisoner claims that clearly lack merit); § 1997e(e) (prohibiting claims for emotional injury without prior showing of physical injury); § 1997e(d) (restricting attorney's fees).

² Requiring proper exhaustion gives prisoners an effective incentive to make full use of the prison grievance process and accordingly provides prisons with a fair opportunity to correct their own errors. This is particularly important in relation to state corrections systems because it is "difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations, and procedures, than the administration of its prisons." Preiser v. Rodriguez, 411 U.S. 475, 491-492, 93 S. Ct. 1827, 36 L. Ed. 2d 439 (1973).

remedies as are available are exhausted." § 1997e (a) (2000 ed.) (emphasis added).

Id. Courts have determined that under the PLRA, exhaustion of administrative remedies is no longer left to the discretion of the district court, but is mandatory. See Booth v. Churner, 532 U.S. 731, 739, 121 S. Ct. 1819, 149 L. Ed. 2d 958 (2001) (emphasis added).

42 USC § 1997e states:

(c) Dismissal

- (1) The court shall on its own motion or on the motion of a party dismiss any action brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility if the court is satisfied that the action is frivolous, malicious, fails to state a claim upon which relief can be granted, or seeks monetary relief from a defendant who is immune from such relief.

Id. (emphasis added).

In order to avoid dismissal, prisoners must exhaust all "available" remedies, not just those that meet federal standards. Moreover, exhaustion of available administrative remedies is required for any suit challenging prison conditions, not just for suits under § 1983. See Nussle, supra, at 524, 122 S. Ct. 983, 152 L. Ed. 2d 12. See Pozo v. McCaughtry, 286 F.3d 1022, 1025 (CA7) ("To exhaust remedies, a prisoner must file complaints and appeals in the place, and at the time, the prison's administrative rules require"), cert. denied, 537 U.S. 949, 123 S. Ct. 414, 154 L. Ed. 2d 293 (2002); Ross v. County of Bernalillo, 365 F.3d 1181, 1185-1186 (CA10 2004) (same); Spruill v. Gillis, 372 F.3d 218, 230 (CA3 2004) (same); Johnson v. Meadows, 418 F.3d 1152, 1159 (CA11 2005) (same).

A prisoner's lack of knowledge regarding the existence of the procedure does not relieve his/her responsibility to exhaust administrative remedies, and failure of officials to

provide grievance forms is not a legitimate defense. See Abney v. McGinnis, 380 F. 3d 663 (2nd Cir. 2004). So long as the prisoner has access to writing material and officials do not interfere with the procedure, the process must be followed to conclusion before suit is filed. Id.

As relevant to the case at bar, PHS has established a simple two-step procedure for identifying and addressing inmate grievances at Kilby Correctional Facility. (See Exhibit “C”). If an inmate has a grievance regarding a healthcare issue he must submit to the healthcare unit an “Inmate Informal Grievance” form. (Id.) These are standard forms that may be acquired in the healthcare unit or from an inmate’s supervising officer in his dormitory. (Id.) The informal grievance allows an inmate to communicate any healthcare related concern by placing the form in the medical services complaint box or mailbox to be forwarded to the healthcare unit. (Id.) Kilby’s Health Services Administrator, Linda Lawrence, R.N., H.S.A., subsequently reviews the concern and responds via in house mail. (Id.)

If the inmate is unsatisfied with H.S.A. Lawrence’s response, he may request an “Inmate Grievance Appeal” form from the healthcare unit. (Id.) This form allows an inmate to again voice his concerns relating to the healthcare issue addressed with the informal grievance form. (Id.) After the inmate has submitted the grievance appeal, H.S.A. Lawrence will meet with him face-to-face in a final attempt to address his concerns verbally. (Id.)

The Plaintiff, Marvin Nation has filed suit in this matter alleging that Dr. Robbins has failed to provide him with appropriate medical care subsequent to being involved in an automobile accident on September 21, 2004. (See Complaint). However, Mr. Nation

has failed to exhaust Kilby's informal grievance procedure relating to the receipt of medical care for this alleged condition. (See Exhibit "C"). Specifically, as relevant to his Complaint, Mr. Nation has submitted neither an inmate informal grievance nor an inmate grievance appeal. (Id.) As such, the healthcare unit at Kilby has not been afforded the opportunity to resolve Mr. Nation's medical complaints prior to filing suit. (Id.)

Since Mr. Nation has failed to extinguish those administrative remedies available for him at Kilby, the Prison Litigation Reform Act of 1995 (PLRA) demands that the Plaintiff's lawsuit be dismissed.

V. CONCLUSION

The Plaintiff's Complaint is due to be dismissed on its face, and is, further, disproven by the evidence now before the Court. All of the Plaintiff's requests for relief are without merit. The Defendant has demonstrated both through substantial evidence and appropriate precedent that there is not any genuine issue of material facts relating to a constitutional violation, and that he is, therefore, entitled to a judgment in his favor as a matter of law. The Plaintiff's submissions clearly fail to meet his required burden. Moreover, since the Plaintiff failed to exhaust those administrative remedies available to him at Kilby prior to filing suit, this case is due to be dismissed pursuant to the PLRA.

Accordingly, the Defendant requests that this Special Report be treated and denominated as a Motion to Dismiss and/or a Motion for Summary Judgment and that this Honorable Court either dismiss the Plaintiff's Complaint, with prejudice, or enter a judgment in his favor.

Respectfully submitted,

s/L. Peyton Chapman, III
Alabama State Bar Number CHA060
s/R. Brett Garrett
Alabama State Bar Number GAR085
Attorneys for Michael E. Robbins,
M.D.

RUSHTON, STAKELY,
JOHNSTON & GARRETT, P.A.
Post Office Box 270
Montgomery, Alabama 36101-0270
Telephone: (334) 834-8480
Fax: (334) 262-6277
E-mail: bg@rsjg.com

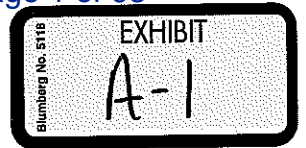
CERTIFICATE OF SERVICE

I hereby certified that I have mailed via U.S. mail, properly addressed and first-class postage prepaid, the foregoing document this 17th day of October, 2006, to the following:

Marvin Nation (AIS # 141669)
Fountain Correctional Facility
3800 Fountain
Atmore, AL 36503

s/R. Brett Garrett
Attorney for Michael E. Robbins,
M.D.

AFFIDAVIT



STATE OF ALABAMA)
)
Montgomery COUNTY)

I, Catherine Stallworth, hereby certify and affirm that I am a Medical Records Supv., at Kilby; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of one Marvin Nation, AIS# 141669; and that I am over the age of twenty-one years and am competent to testify to the aforesaid documents and matters stated therein.

I further certify and affirm that said documents are maintained in the usual and ordinary course of business at Kilby; and that said documents (and the entries therein) were made at, or reasonably near, the time that by, or from information transmitted by, a person with knowledge of such acts, events, and transactions referred to therein are said to have occurred.

This, I do hereby certify and affirm to on this the 22nd day of September, 2006.

Catherine Stallworth

SWORN TO AND SUBSCRIBED BEFORE ME THIS THE 22nd Day of September, 2006.

Cynthia R. Evans

Notary Public

6-15-08

My Commission Expires



PHYSICIANS' ORDERS

NAME: Nation, Marvin Fountain CC #141669 DOB: [REDACTED] ALLERGIES: NKDA Use Last Date 8/17/06	DIAGNOSIS (If Chg'd) 1) Abdom Binder 2) Bactrim DS ÷ 70 BID x 14 days (start from stock) 3) Work Profile Use 8/17/06 R. Ballard RN Shawn George... <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Nation, Marvin FCC #141669 DOB: [REDACTED] ALLERGIES: NKDA Use Fourth Date 8/12/06	DIAGNOSIS (If Chg'd) 1) Cont INH 300mg ⁱⁱⁱ po q Sun. Am & Thursday pm until 4-14-07 2) Cont Vitamin B-6 25mg ÷ po q Sun Am & Thurs pm until 4-14-07 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Nation, Marvin 141669 DOB: [REDACTED] ALLERGIES: NKDA Use Third Date 7/17/06	DIAGNOSIS (If Chg'd) CEL-TB CXR INH 300mg ÷ po qd x 9 months Vit. B6 25mg ÷ po qd x 9 months profile 12 po. Adams Camp / RM <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Nation, Marvin 141669 DOB: [REDACTED] ALLERGIES: NKDA Use Second Date 7/17/06	DIAGNOSIS (If Chg'd) 1) Abdominal Binder x 180d (KOP) 2) Motrin 600 mg p.o. BID x 30d PRN 3) BB / straining / lift > 20 # x 180d <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Nation, Marvin 141669 DOB: [REDACTED] ALLERGIES: NKDA Use First Date 7/17/06	DIAGNOSIS Camp, Cho, Etc. <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED



PROGRESS NOTES

Date/Time	Inmate's Name:	D.O.B.:
8-17-06	Nations, Marvin	1 / 1
NKDA	Wt. 195 T. 97.7 P. 69 R. 16 B/P 118/79	
	Abail	
	S: Pt has area under axilla. Pt also has umbilical hernia by report. Voice has grown large in last few months.	
	O: Dent Note three small open areas & yellowish-white drainage @ axilla.	
	Abail: Note 3cm by 3cm round umbilical hernia. Area is reducible.	
	A: 1) Boils @ axilla	
	2) Umbilical hernia	
	P: 1) Will monitor umbilical hernia	
	2) Abd binder.	
	3) Bactrim DS r' PO BID x 14 days (start from stock)	
	4) Warts profile given.	
8/	<i>[Signature]</i>	



Nursing Evaluation Tool:

General Sick Call

Facility: Alabama Department of Corrections

Patient Name: Nation, MarvinInmate Number: 1411669Date of Report: 8 / 18 / 2006Date of Birth: [REDACTED]Time Seen: 2028 AM / PM Circle One

Subjective: Chief Complaint(s): % ID band causing outbreak around wrist
Onset: Last Sunday, 8-13-06

Brief History: NKA
(Continue on back if necessary)

☐ Check Here if additional notes on back

Objective: Vital Signs: (As Indicated) T: 97.6 P: 75 RR: 18 B/P: 125 / 81 03/95/6
wt 18

Examination Findings: Red patches around wrist area where band is worn. Other areas of redness noted. % of itching. Cold H₂O helps relieve. Some blistering noted where inmate has scratched area.

☐ Check Here if additional notes on back

Assessment: (Referral Status)

Preliminary Determination(s): % possible allergic reaction to ID band☒ Referral NOT REQUIRED☐ Referral REQUIRED due to the following: (Check all that apply)☐ Recurrent Complaint (More than 2 visits for the same complaint)☐ Other: _____

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

☐ Instructions to return if condition worsens☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)☐ Other: _____

OTC Medications given ☐ NO ☒ YES (If Yes List): Benedryl 50mg po x 1 dose

Referral: ☒ NO ☐ YES (If Yes, Whom/Where): _____ Date for referral: 8 / 18 / 06Referral Type: ☐ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time: _____

x [Signature]
Nurse's Signature

Name: Scott David Upm 8-18-06
Printed

Facility: Alabama Department of Corrections

Patient Name: Nation, Marvin

Inmate Number: 141669

Date of Birth: [REDACTED]

Date of Report: 8/18/2006

Time Seen: 2025 AM/PM Circle One

Subjective: Chief Complaint(s): I have a bad cavity that is breaking and chipping off when I eat. I want to get it filled before it loses it.
Onset: about 1 wk

History: N/A
(Continue on back if necessary)

Is the problem: ☒ New ☐ Chronic Problem related to: ☐ Recent trauma ☐ Recent dental work ☐ Other: ☐ Check Here if additional notes on back
Injury sustained in altercation with custody staff, or other inmate: ☒ NO ☐ YES (Requires notification of correctional staff)
Dental Pain: Right: ☐ Upper Back ☐ Upper Front ☐ Lower Back Left: ☐ Upper Back ☒ Upper Front ☐ Lower Back
☐ Lower Front
Type of Pain: ☐ Aching ☒ Throbbing ☐ Dull ☒ Sharp ☐ Constant ☒ Intermittent
Sensitive to Hot or Cold: ☐ No ☐ Hot ☐ Cold ☒ Sensitive to both Hot & Cold Pain Scale: (1-10) 7
Associated Symptoms: ☐ Sinus problems ☐ Difficulty chewing ☐ Earache ☐ Sore throat ☐ Other: _____

Objective: Vital Signs: (If Indicated) T: 97.6 P: 75 RR: 18 B/P: 125/81 Obs 9: wt 195
Visual evidence of tooth decay/fracture ☐ No ☒ Yes Visible external swelling ☒ No ☐ Yes
Visual evidence of missing filling ☒ No ☐ Yes Swelling/redness/pus surrounding affected tooth: ☒ No ☐ Yes
Pain upon opening jaw widely ☐ No ☒ Yes Evidence of trauma/injury to jaw/face ☐ No ☐ Yes
☒ Additional Examination: Teeth are in poor condition. 8/10 of occlusal surface holed.
(Continue on back if necessary)

Assessment: (Referral Status)

Preliminary Determination(s): _____

☐ Referral Not Required

☒ Referral Required due to the following: (Check all that apply)

- ☐ Fever ☐ Evidence of pus collection or swelling
☐ Earache/sore throat/sinus problems ☐ Recent dental surgery/procedure
☒ Pain upon opening mouth widely ☐ Significant injury/trauma to jaw ☐ Recurrent Complaint (More than 2 visit)
☒ Other: Tooth ch. ps when eating
(Describe)

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- ☒ For tooth pain; instruct patient to avoid hot/cold food; to chew on the opposite side of the tooth pain and to do salt water gargles PRN
☒ Warm rinses PRN (Note: DO NOT apply warm compress to outside of face for dental abscess)
☐ Cold Compress PRN for minor trauma
☒ Instructions to return if condition worsens.
☒ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do well as appropriate follow-up ☒ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
☐ Other: _____
(Describe)

☒ OTC Medications given (Motrin 400 or Tylenol 650 mg Bid pm x 2 days) ☐ NO ☒ YES (If Yes List): _____

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. Crawford Date for referral: 8/18/06

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

x [Signature] Name: S. Gailhard CPN 8-18-06
Nurses Signature Printed



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

FOUNTAIN

Print Name: MARVIN NATION Date of Request: 8-17-06
 ID # 141669 Date of Birth: [REDACTED] Location: 4-36
 Nature of problem or request: I need to see the
dentist as soon as possible. I need to have one
of my eye teeth filled
Thank you
Marvin Nation
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	AUG 18 2006
Time:	
Receiving Nurse Initials	<u> </u>

(S)ubjective:

(O)bjective (V/S): T: P: R: BP: WT:

(A)ssessment:

(P)lan:

Seen at sick call 8-17-06
Marvin Nation

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



Facility: Alabama Department of Corrections
Patient Name: Nation Marvin
Inmate Number: 141669 Last First
Date of Birth: [REDACTED] MM DD YYYY
Date of Report: 08/16/2006 MM DD YYYY
Time Seen: 2135 AM (PM) Circle One

Subjective: Chief Complaint(s): (2) boils underarm, hernia on navel
Onset: boils underarm 3-4 days, hernia on navel 1 month

History: Unknown
(Continue on back if necessary)

5/19/20 Drainage: ☒ No ☐ Yes History of Diabetes? ☒ No ☐ Yes Recent hospitalization? ☒ No ☐ Yes
Contact with MRSA infected patients? ☒ No ☐ Yes Previous diagnosis or treatment for MRSA? ☒ No ☐ Yes
4/19/5 Objective: Vital Signs: (As Indicated) T: 98.0 P: 68 RR: 18 B/P: 128/100

Abscess Description: ☒ Tense ☐ Fluctuant ☐ Drainage (Sample of Drainage Obtained for Culture): ☐ YES ☒ NO
Check all that apply
Size (measurement) of Abscess: _____ Location of Abscess: Under arm
☐ Additional Examination: _____
(Continue on back if necessary)

Assessment: (Referral Status)

☐ Referral NOT Required

Referral may not be required if the following parameters have been met:

(1) Small, Non-fluctuant abscess (2) No drainage/pus (3) Afebrile and (4) Patient is not HIV+ or a diabetic.

☒ Referral Required due to the following: (Check all that apply)

☒ Febrile ☐ Presence of inflammation / edema of surrounding area ☐ Drainage ☐ Diabetes
☒ Recurrent Complaint (More than 2 visits for the same complaint) ☐ Other (Describe): boils underarms

Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.

Plan: Check All That Apply:

- ☐ Dry, sterile, dressing applied
- ☐ Obtain sample of drainage for culture and sensitivity if significant or persistent infection exists
- ☒ Instruct patient to apply warm compresses x 20 minutes 2-4 times daily.
- ☐ Contact isolation (not required if lesion is small, easily covered, and inmate understands and is compliant).
Required for: Any inmate who is unable/unwilling to understand follow-up management or who is non-compliant with active therapy
Any inmate with a large abscess, boil, or draining lesion that cannot be adequately covered and kept clean and dry.
- ☐ Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. ☐ YES ☐ NO (If NO then schedule patient for appropriate follow-up visits)
- ☐ Report made to security and infection control team regarding possible MRSA. ☐ Entry made in MRSA log of potential case.
- ☐ Instructions to return if condition worsens
- ☐ Other: _____

OTC Medications given ☒ NO ☐ YES (If Yes List): _____ (Describe)

Referral: ☐ NO ☒ YES (If Yes, Whom/Where): Dr. Barnes Date for referral: 1/1/ MM DD YYYY

Referral Type: ☒ Routine ☐ Urgent ☐ Emergent (if emergent who was contacted?): _____ Time _____

C. Campbell MD Name: Courtney Campbell MD



FOUNTAIN

**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: MARVIN NATION Date of Request: 8-15-06
ID # 141669 Date of Birth: [REDACTED] Location: 4-360
Nature of problem or request: I've Got 2 big knots under
my arm pit THAT ARE Hurting real BAD, Knot on navel

Marvin Nation

Signature

DO NOT WRITE BELOW THIS LINE

Date: 08/16/2006
Time: 0135 AM PM
Allergies: NKA

<p>RECEIVED</p> <p>Date: AUG 16 2006</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>
--

(S)ubjective:

008at 9770

(O)bjective (V/S): T: 98.0 P: 68 R: 18 BP: 128/100 WT: 195

(A)ssessment: man seen @ Sick call 8/10/06

(P)lan: see net tool

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

C. Campbell MD

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



DEPARTMENT OF CORRECTIONS
TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record Institution: <u>Fcc</u> Date: <u>8/12/06</u> Time: <u>0940</u> AM/PM RECEIVED FROM: Institution/Work Release Center/Free-World Hospital	RELEASED: Inmate/Health Record Institution: <u>Kilby</u> Date: <u>8-10-06</u> Time: <u>1800</u> AM/PM RELEASE FROM: <input type="checkbox"/> Infirmary <input type="checkbox"/> Segregation <input type="checkbox"/> Population <input type="checkbox"/> Mental Health <input type="checkbox"/> Other _____ RELEASE TO: <input checked="" type="checkbox"/> DOC <input type="checkbox"/> Infirmary <input type="checkbox"/> Mental Health <input type="checkbox"/> _____ Institution/Work Release Center/Free-World Hospital	ALLERGIES: <u>NKDA</u> PHYSICAL EXAMINATION Date of last exam: _____ Chest X-Ray Date: _____ Result: _____ PPD Reading <u>PPD 15mm</u> Classification: _____ Limitations: _____
RECEIVING MEDICAL STATUS <input checked="" type="checkbox"/> Population <input type="checkbox"/> Infirmary <input type="checkbox"/> Isolation		

LAB RESULTS -- LAST REPORT		YES	NO
CBC	Date <u>7-18-06</u> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/>	Wears Glasses/Contacts <input type="checkbox"/>	<input checked="" type="checkbox"/>
Urinalysis	Date <u>7-17-06</u> Normal <input type="checkbox"/> Abnormal <input checked="" type="checkbox"/>	Dental Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
		Hearing Aide <input type="checkbox"/>	<input checked="" type="checkbox"/>
		Other Prosthesis <input type="checkbox"/>	<input checked="" type="checkbox"/>
			<u>Receiving Nurse</u>

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

umbilical Hernia ; (+) PPD, Head injury sec 0 mva

CURRENT MEDICATION -- DOSAGE AND FREQUENCY

INH 300mg po qd
Vit B 25mg po qd

MEDICATIONS	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
X-RAY FILM	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
HEALTH RECORD	<input type="checkbox"/> Sent w / inmate	<input type="checkbox"/> Not sent w / inmate
Released to: _____		

Date: _____ Time: _____ AM/PM

MEDICATIONS	<input type="checkbox"/> Received	<input type="checkbox"/> Not Received
X-RAY FILM	<input type="checkbox"/> Received	<input type="checkbox"/> Not Received
HEALTH RECORD	<input checked="" type="checkbox"/> Received	<input type="checkbox"/> Not Received
CHART REVIEWED	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO

Received by: M. Barb...
Signature of Receiving Nurse

Date: 8/12/06 Time: 0940 AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

FOLLOW-UP CARE NEEDED	Date	Time	With Whom -- Location (Sending Nurse)	Date/Appt Made w/Whom (Rec Nurse)
<input checked="" type="checkbox"/> Medical <input type="checkbox"/> Dental			<u>R. Bar...</u> <u>Fcc</u>	<u>8/22/06</u> <u>M. Barb...</u>
<input type="checkbox"/> Mental Health				

NURSING ASSESSMENT (SENDING NURSE)		NURSING ASSESSMENT (RECEIVING NURSE)	
(Noted from health record documentation)		(Noted from inmate assessment)	
HISTORY	Yes No	SKIN	Yes No
Drug Use	<input checked="" type="checkbox"/> <input type="checkbox"/>	Open Sores	<input type="checkbox"/> <input checked="" type="checkbox"/>
Mental Illness	<input type="checkbox"/> <input checked="" type="checkbox"/>	Lice	<input type="checkbox"/> <input checked="" type="checkbox"/>
Suicide Attempt	<input type="checkbox"/> <input checked="" type="checkbox"/>	Edema	<input type="checkbox"/> <input checked="" type="checkbox"/>
Chronic Care	<input type="checkbox"/> <input checked="" type="checkbox"/>	Warm & Dry	<input checked="" type="checkbox"/> <input type="checkbox"/>
		Cool & Moist	<input type="checkbox"/> <input checked="" type="checkbox"/>
STATUS	Yes No	CONDITION	Yes No
Special Diet	<input type="checkbox"/> <input checked="" type="checkbox"/>	Alert	<input checked="" type="checkbox"/> <input type="checkbox"/>
Appearance	<input type="checkbox"/> <input checked="" type="checkbox"/>	Oriented	<input checked="" type="checkbox"/> <input type="checkbox"/>
OTHER PERTINENT NURSING ASSESSMENT		Uncooperative	<input type="checkbox"/> <input checked="" type="checkbox"/>
		Depressed	<input type="checkbox"/> <input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained	<input checked="" type="checkbox"/>
Height	<u>6'1"</u>
Weight	<u>193</u>
Blood Pressure	<u>118/74</u>
Temperature	<u>97.5</u>
Pulse Resp	<u>62-18</u>
Other	

Signature of Nurse Completing Assessment (Sending Nurse) A. Brown, R.N. Date 8-10-06 Signature of Intake Screening Nurse (Receiving Nurse) M. Barb... Date 8/12/06

INMATE NAME (LAST FIRST MIDDLE)	DOC#	DOB	Race/Sex	FAC
<u>Norton, Michael</u>	<u>141669</u>	<u>[REDACTED]</u>	<u>W/M</u>	<u>KC6</u>

Facility Name	Bactrim DS P.O. B. OX 14 Days																													
Hour	<div> <div>0500</div> <div>1700</div> </div> <div> <div>8/17/06</div> <div>8/31</div> </div> <div> <div>S. Geographical</div> <div>RX # 28</div> </div>																													
Start Date	8/17/06																													
Stop Date	8/31																													
Hour	<div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>																													
Start Date																														
Stop Date																														
Hour	<div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>																													
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Stop Date																														
Hour	<div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>																													
Start Date																														
Stop Date																														
Hour	<div>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</div>																													
Start Date																														
Stop Date																														

Diagnosis: R Buprenorphine

WKA

PCP 141669

Idg II

Facility Name: TCA

Motrin 400 mg $\frac{1}{2}$ po
Bid x 2 days

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	
0500																																
1700																																

Start Date: 8-19-06 Prescriber: NSG protocol
Stop Date: 8-20-06 RX #:

Benadryl 50 mg $\frac{1}{2}$ po
x 1 dose

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	
0500																																
1700																																

Start Date: 8-18-06 Prescriber: NSG protocol
Stop Date: _____ RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	

Start Date: _____ Prescriber: _____
Stop Date: _____ RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	

Start Date: _____ Prescriber: _____
Stop Date: _____ RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	

Start Date: _____ Prescriber: _____
Stop Date: _____ RX #:

Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3	

Start Date: _____ Prescriber: _____
Stop Date: _____ RX #:

Diagnosis: NEPA

Nurse 1 Signature: _____ Nurse 2 Signature: [Signature] SN

141669

Motrin 400mg $\frac{1}{2}$ po

Benadryl

Facility Name: Kilby Correctional Facility		Month: 08/06																													
Motrin 600MG Tab 60.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Take 1 tablet(s) by mouth twice daily as needed	0900	[Handwritten signature]																													
	1600	[Handwritten signature]																													
	Start Date	07-19-2006										Prescriber										Adams, Bradford									
	Stop Date	08-17-2006										RX #										251739622									
Isoniazid 300MG Tab 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Take 1 tablet(s) by mouth daily	0900	[Handwritten signature]																													
	Start Date	07-19-2006										Prescriber										Adams, Bradford									
	Stop Date	04-14-2007										RX #										251738758									
Vitamin B-6 25MG Tab 30.00	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Take 1 tablet(s) by mouth daily	0900	[Handwritten signature]																													
	Start Date	07-19-2006										Prescriber										Adams, Bradford									
	Stop Date	04-14-2007										RX #										251738759									
INH 300mg $\frac{1}{4}$ po Q Sun & Thurs	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	0700	[Handwritten signature]																													
	1630	[Handwritten signature]																													
	Start Date	7-19-06										Prescriber										Bradford/Barnes									
	Stop Date	4-14-07										RX #																			
Vit B-6 25mg + po Q Sun & Thurs	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	0700	[Handwritten signature]																													
	1630	[Handwritten signature]																													
	Start Date	7-19-06										Prescriber										Bradford/Barnes									
	Stop Date	4-14-06										RX #																			
	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
	Start Date											Prescriber																			
	Stop Date																														
Diagnosis	Hansen's Cx 80 ab. Green Lm dy																														

Population
141669

Ref
Nutrin 600g
po. Bid X3 od.
pmr

Hour
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Start Date 7-17-6
Stop Date 8-17-6

Adm

7/6
MLT
[Signature]

INH 300mg
po, qox qms

Hour

Start Date 7-17-6
Stop Date 4-18-7

Adm

MLT
[Signature]

Vit b6 25g
po qox qms

Hour

Start Date 7-17-6
Stop Date 4-18-7

Adm

MLT
[Signature]

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date Prescriber

Stop Date RX

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

Start Date Prescriber

Stop Date RX

Hour 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30

MDA

[Signature]

2 [Signature]

141669

7/16/06

Specimen # 233-007-0255-0		Controlled No. 516761 720		Pg 1	LabCorp V 1.28
Fasting N/A	Micro Source	Total Urine Volume	Report Status S / Final		
Date Collected 08/21/06	Time Collected	Date Entered 08/21/06	Date Reported 08/25/06		
Patient ID Number 141669		Patient Phone Number	Patient SSN	Account 01510065	
Patient Name NATION, MARVIN		Sex M	Date of Birth	Fountain Correctional Facility Prison Health Services 01 9677 Hwy 21 Atmore AL 36503	
Patient Address		Comments PATIENT AGE: 040/05/02		251-368-8122 PROV:	
Tests Requested Aerobic Bacterial Culture; Sensitivity Organism #1; Organism ID					

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
Aerobic Bacterial Culture					
Aerobic Bacterial Culture					
Result 1					MB
Methicillin - resistant Staphylococcus aureus					MB
Heavy growth					
Susceptibility or resistance of staphylococci to oxacillin predicts susceptibility or resistance to (a) other beta-lactamase-stable penicillins such as cloxacillin and dicloxacillin, (b) combinations of a penicillin and a beta-lactamase inhibitor, and (c) anti-staphylococcal cephalosporins. Routine testing of other penicillins, beta-lactam/beta-lactamase inhibitor combinations, cepheems, and carbapenems is not advised by the CLSI Standards (M100-S15, 2005).					
Antimicrobial Susceptibility					
***** S = Susceptible; I = Intermediate; R = Resistant *****					
P=Positive, N=Negative					
MICS are expressed in micrograms per mL					
Antibiotic	RSLT#1	RSLT#2	RSLT#3	RSLT#4	
Ciprofloxacin	S				
Clindamycin	S				
Erythromycin	R				
Gentamicin	S				
Levofloxacin	S				
Linezolid	S				
Oxacillin	R				
Penicillin	R				
Rifampin	- S -				
Tetracycline	S				
Trimethoprim/Sulfa	- S -				
Vancomycin	S				
Lab: MB LabCorp Birmingham Director: John Elgin, MD					
1801 First Avenue South, Birmingham, AL 35233					
For inquiries, the physician may contact: Branch: 251-342-1611 Lab: 205-581-3500					
LAST PAGE OF REPORT					

FINAL REPORT

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NATION, MARVIN

141669

233-007-0255-0 Seq# 5566 08-25-06 07:52ET

Bureau Clinical Laboratories-Montgomery

PO BOX 244018, MONTGOMERY AL 36124-4018

Phone:(334) 260-3400 FAX:(334) 274-9800

Page: 1

Provider:

KILBY CORRECTIONAL FACILITY
P O BOX 150
MT MEIGS, AL 36057-0000
(334) 215-6600,
UNKNOWN DOCTOR

Accession

Requisition #: 183504
Service Area:
CHR #: 141669

ID:**1049191****Patient:****Nation, Marvin,**

D O B : [REDACTED]

Sex: M MALE

Phone: (000) 000-0000

Collected: 7/24/2006 @

Received: 7/25/2006 @ 8:11 AM

Reported: 7/25/2006 @ 3:09 PM

Status: Final Report

Test Name	Result	Units	Normal Range	Notes
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Comprehensive Metabolic Panel

Glucose	93	mg/dL	55 - 115	
Urea Nitrogen	15	mg/dL	6 - 20	
Creatinine	1.0	mg/dl	0.5 - 1.2	
Sodium	141	mEq/L	133 - 145	
Potassium	4.0	mEq/L	3.3 - 5.1	
Chloride	103	mEq/L	96 - 108	
Bicarbonate	25.0	mEq/L	22.0 - 29.0	
Calcium	9.8	mg/dl	8.4 - 10.2	
AST (SGOT)	18	U/L	0 - 38	
ALT (SGPT)	20	U/L	0 - 41	
Alkaline Phosphatase	88	U/L	40 - 129	
Bilirubin, Total	0.5	mg/dL	0.0 - 1.0	
Total Protein	7.4	g/dL	6.4 - 8.3	
> Albumin	4.8	AH g/dL	3.2 - 4.5	

Report Summary**Abnormal Summary**

> Albumin	4.8	AH g/dL	3.2 - 4.5
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7/28/06

Lab Director

William J. Callan, Ph.D.



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN 199-205-5677-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				
PE 7/17	FASTING: N DOB: [REDACTED]			
PATIENT NAME NATION, MARVIN		SEX M	AGE(YR/MOS.) 40 / 3	
PT. ADD:				
DATE OF COLLECTION TIME 7/18/2006 8:23	DATE RECEIVED 7/18/2006	DATE REPORTED 7/19/2006	TIME 7:20	4434

CLINICAL INFORMATION CD- 41139334230	
PHYSICIAN ID ROBBINS M	PATIENT ID 141669
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
CMP14+LP+5AC			
Chemistries			MB
> Glucose, Serum	127 H mg/dL	65 - 99	MB
Uric Acid, Serum	4.7 mg/dL	2.4 - 8.2	MB
BUN	17 mg/dL	5 - 26	MB
Creatinine, Serum	1.0 mg/dL	0.5 - 1.5	MB
BUN/Creatinine Ratio	17	8 - 27	
Sodium, Serum	141 mmol/L	135 - 148	MB
Potassium, Serum	3.9 mmol/L	3.5 - 5.5	MB
Chloride, Serum	105 mmol/L	96 - 109	MB
Carbon Dioxide, Total	23 mmol/L	20 - 32	MB
Calcium, Serum	9.9 mg/dL	8.5 - 10.6	MB
Phosphorus, Serum	3.4 mg/dL	2.5 - 4.5	MB
Protein, Total, Serum	7.3 g/dL	6.0 - 8.5	MB
Albumin, Serum	4.7 g/dL	3.5 - 5.5	MB
Globulin, Total	2.6 g/dL	1.5 - 4.5	
A/G Ratio	1.8	1.1 - 2.5	
Bilirubin, Total	0.7 mg/dL	0.1 - 1.2	MB
Alkaline Phosphatase, Serum	87 IU/L	25 - 150	MB
LDH	135 IU/L	100 - 250	MB
AST (SGOT)	18 IU/L	0 - 40	MB
ALT (SGPT)	21 IU/L	0 - 55	MB
GGT	16 IU/L	0 - 65	MB
> Iron, Serum	162 H ug/dL	40 - 155	MB
Lipids			MB
> Cholesterol, Total	212 H mg/dL	100 - 199	MB
> Triglycerides	249 H mg/dL	0 - 149	MB
> HDL Cholesterol	31 L mg/dL	40 - 59	MB
> VLDL Cholesterol Cal	50 H mg/dL	5 - 40	
> LDL Cholesterol Calc	131 H mg/dL	0 - 99	

Comment MB

If initial LDL-cholesterol result is >100 mg/dL, assess for risk factors.

> T. Chol/HDL Ratio	6.8 H	ratio units	0.0 - 5.0
> Estimated CHD Risk	1.4 H	times avg.	0.0 - 1.0

T. Chol/HDL Ratio

	Men	Women
1/2 Avg Risk	3.4	3.3
Avg Risk	5.0	4.4

Pat Name: NATION MARVIN

Pat ID: 141669

Spec #: 199-205-5677-0

Seq #: 4434

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page

④



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS	Page #:
199-205-5677-0	S	MB	COMPLETE	2

ADDITIONAL INFORMATION

PE	FASTING N				
7/17	DOB [REDACTED]				
PATIENT NAME		SEX	AGE(YR./MOS.)		
NATION, MARVIN		M	40 / 3		
PT. ADD :					
DATE OF COLLECTION TIME		DATE RECEIVED	DATE REPORTED	TIME	
7/18/2006 8:23		7/18/2006	7/19/2006	7:20	4434

CLINICAL INFORMATION

CD- 41139334230

PHYSICIAN ID ROBBINS M	PATIENT ID. 141669
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

2X Avg. Risk 9.6 7.1
3X Avg. Risk 23.4 11.0

The CHD Risk is based on the T Chol/HDL ratio. Other factors affect CHD Risk such as hypertension, smoking, diabetes, severe obesity, and family history of pre-mature CHD.

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

Pat Name: NATION, MARVIN

Pat ID: 141669

Spec #: 199-205-5677-0

Seq #: 4434

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

④



LabCorp Birmingham
1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN 198-205-5091-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION NPY3 FASTING: N DOB: [REDACTED]				
PATIENT NAME NATION, MARVIN		SEX M	AGE(YR / MOS) 40 / 3	
PT. ADD:				
DATE OF COLLECTION TIME 7/17/2006 6:00	DATE RECEIVED 7/17/2006	DATE REPORTED 7/18/2006	TIME 9:31	4393

CLINICAL INFORMATION CD- 41139334143	
PHYSICIAN ID ROBBINS M	PATIENT ID 141669
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

TEST	RESULT	LIMITS	LAB
------	--------	--------	-----

CBC With Differential/Platelet

WBC	8.2	x10E3/uL	4.0 - 10.5	MB
RBC	5.18	x10E6/uL	4.10 - 5.60	MB
Hemoglobin	15.1	g/dL	12.5 - 17.0	MB
Hematocrit	43.5	%	36.0 - 50.0	MB
MCV	84	fL	80 - 98	MB
MCH	29.1	pg	27.0 - 34.0	MB
MCHC	34.6	g/dL	32.0 - 36.0	MB
RDW	13.5	%	11.7 - 15.0	MB
Platelets	223	x10E3/uL	140 - 415	MB
Neutrophils	55	%	40 - 74	MB
Lymphs	35	%	14 - 46	MB
Monocytes	9	%	4 - 13	MB
Eos	1	%	0 - 7	MB
Basos	0	%	0 - 3	MB
Neutrophils (Absolute)	4.5	x10E3/uL	1.8 - 7.8	MB
Lymphs (Absolute)	2.9	x10E3/uL	0.7 - 4.5	MB
Monocytes (Absolute)	0.7	x10E3/uL	0.1 - 1.0	MB
Eos (Absolute)	0.1	x10E3/uL	0.0 - 0.4	MB
Baso (Absolute)	0.0	x10E3/uL	0.0 - 0.2	MB

Urinalysis, Complete

Urinalysis Gross Exam MB

>	Specific Gravity	1.037H	1.005 - 1.030	MB
	pH	5.5	5.0 - 7.5	MB
	Urine-Color	Amber	Yellow	MB
	Appearance	Clear	Clear	MB
	WBC Esterase	Negative	Negative	MB
	Protein	Negative	Negative/Trace	MB
	Glucose	Negative	Negative	MB
	Ketones	Negative	Negative	MB
	Occult Blood	Negative	Negative	MB
>	Bilirubin	1+	Negative	MB
	Urobilinogen, Semi-Qn	0.0 mg/dL	0.0 - 1.9	MB
	Nitrite, Urine	Negative	Negative	MB
	Microscopic Examination	See below:		MB
	WBC	None seen /hpf	0 - 5	MB
	RBC	None seen /hpf	0 - 3	MB
>	Crystals	>	N/A	MB

Few calcium oxalate crystals

Panel 083824

Pat Name: NATION MARVIN	Pat ID: 141669	Spec #: 198-205-5091-0	Seq #: 4393
-------------------------	----------------	------------------------	-------------

Results are Flagged in Accordance with Age Dependent Reference Ranges

Continued on Next Page





LabCorp Birmingham

1801 First Avenue South, Birmingham, AL 35233-0000

Phone: 205-581-3500

SPECIMEN 198-205-5091-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	Page #: 2
ADDITIONAL INFORMATION				
NPY3 FASTING N DOB [REDACTED]				
PATIENT NAME NATION, MARVIN		SEX M	AGE(YR/MOS) 40 / 3	
PT. ADD.:				
DATE OF COLLECTION TIME 7/17/2006 6:00	DATE RECEIVED 7/17/2006	DATE REPORTED 7/18/2006	TIME 9:31	4393

CLINICAL INFORMATION CD- 41139334143	
PHYSICIAN ID ROBBINS M	PATIENT ID 141669
ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt Meigs AL 36507-0000	
ACCOUNT NUMBER: 01306900	

IESI	RESULT	LIMITS	LAB
HIV-1 Abs-EIA			MB
HIV-1 Abs-O.D. Ratio	<1.00	<1.00	MB
O.D. Ratio: Specimen absorbance value relative to the negative cutoff.			
HIV-1 Abs, Qual	Non Reactive	Non Reactive	MB
RPR	Non Reactive	Non Reactive	MB

LAB: MB LabCorp Birmingham

DIRECTOR: John Elgin N MD

1801 First Avenue South, Birmingham, AL 35233-0000

Pat Name: NATION, MARVIN

Pat ID: 141669

Spec #: 198-205-5091-0

Seq #: 4393

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

HEALTHCARE CORRECTIONS.

PE

Name: Nathan, Marcus

State ID No.: 141669

DOB _____

Race: B (W) Sex: M

INSTITUTION: Kilby

E-50

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP

Adams / Loss: tie

Date of request

Time of request

Routine

~~Priority~~

Transportation or special need

HISTORY/DIAGNOSIS:

+ PRO

APOTHECARY			
ABDOMEN/TH	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OS CALCI (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	HIP	PELVIS	THORACIC SPINE
✓ CHEST PA / LATERAL	HUMERUS	RADICULUS	TRIANGLE
COCYX	KNEE	FEET	TOES
CONE DOWN BELL TURKICA	LUMBAR SPINE	SACRO-ILIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

Nation

REPORT

REPORT
PA Chest: The heart is not enlarged. The lungs show mildly increased interstitial markings but are otherwise clear.

IMPRESSION: THE CHEST IS UNREMARKABLE EXCEPT FOR INCREASED INTERSTITIAL LUNG MARKINGS. IF AN ACUTE INFILTRATE IS SUSPECTED FOLLOW UP IS RECOMMENDED.

D: & T: 07-18-06 Howard P. Schiele, M.D /rr Board Certified Radiologist (Signature on file)

X-RAY TECHNOLOGIST'S NAME (PRINT)

X-RAY TECHNOLOGIST'S SIGNATURE:

DATE TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE _____

DOI: 10.1002/for

ELG

AREA OF TREATMENT (CIRCLE)

RECORD OF TREATMENT

Patient's Last Name		First	Middle	Age	R/S	ID No
N. Anthony		Marisa		40	u	141669

#141664

ID: #STAT#060719093129

Action, Manu

07/19/2006 9:31:28

D.O.B.:
Meds:
Class:
Dr.:
Tech:

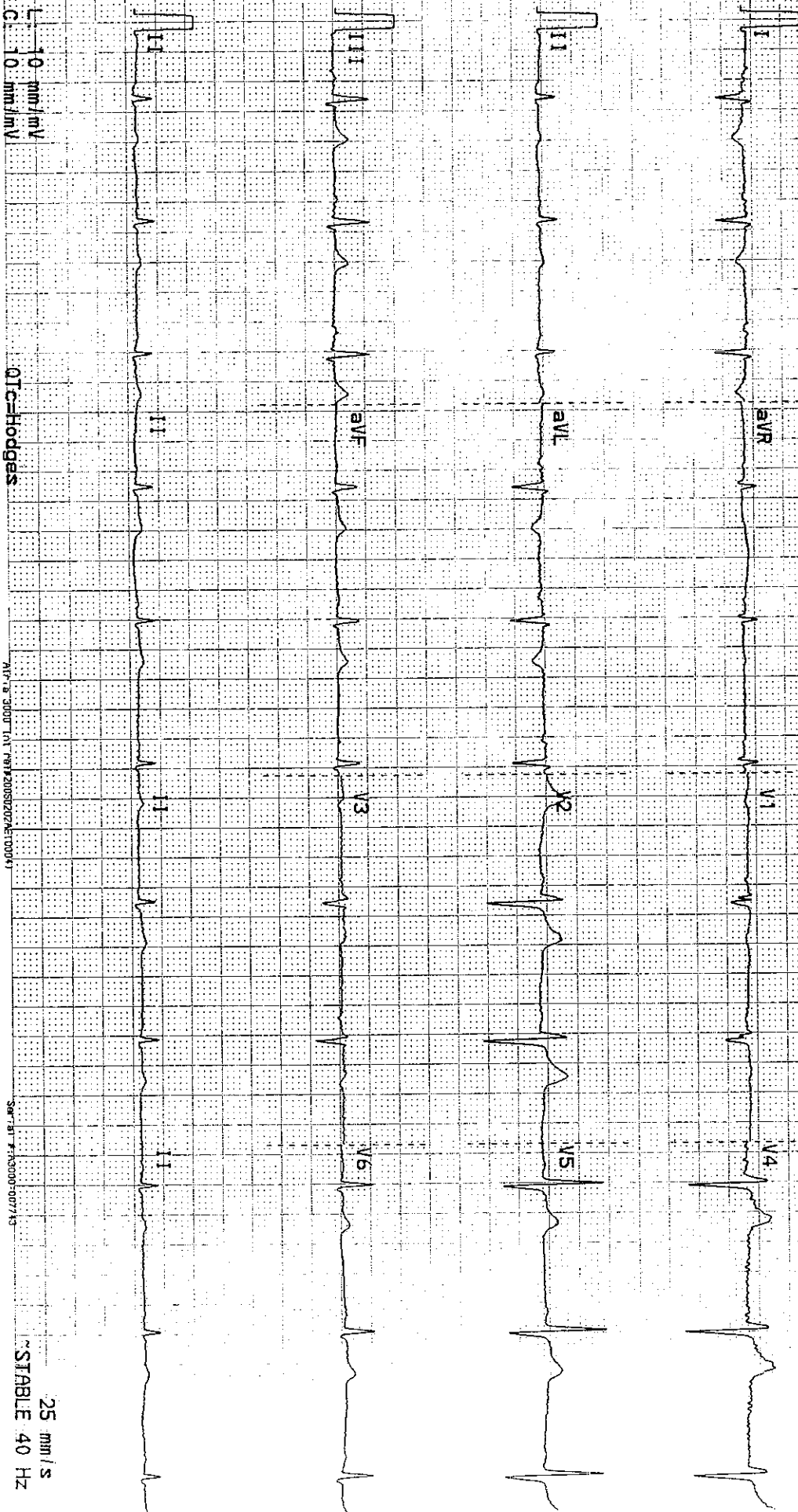
Vent. Rate:	64 bpm
RR Interval:	936 ms
PR Interval:	148 ms
QRS Duration:	96 ms
QT Interval:	404 ms
QTc Interval:	411 ms
QT Dispersion:	64 ms
P-R-T AXIS:	120° 127° 130°

SINUS RHYTHM
** INTERPRETATION MADE WITHOUT KNOWING PATIENT'S GENDER/AGE **
SUGGESTS ARM LEAD REVERSAL - ONLY LEADS aVF, V1 - V6 ANALYSED
NO OTHER FINDING

Summary: AVAILABLE LEADS NORMAL

* Unconfirmed Analysis *

(A)





DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	RESTORATIONS AND TREATMENTS
Date of Initial Examination <u>7-17-06</u>	Initial Classification

Oral Pathology	Gingivitis	
	Vincent's Infection	
	Stomatitis	
	Other Findings	
Occlusion		
Roentgenograms	Periapical	
	Bitewing	
	Other	

Health Questionnaire

YES	NO		YES	NO	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input checked="" type="checkbox"/>	V.D.
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Allergy (Novocaine, penicillin, etc.)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Present Medication	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Anemia or Bleeding Problems
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Heart Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Asthma	<input type="checkbox"/>	<input checked="" type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input checked="" type="checkbox"/>	HIV	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other Disease

SERVICES RENDERED

Date	Tooth #	DX	TX	Initials	Class
7-17-06	Full		CHI	AK	

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Nation, Marvin	141669		W	KCF

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Nation, Marvin AIS# 141669Medication Allergies: AKDAMedical: Chronic (Long-Term) Problems
Roman Numerals for Medical/SurgicalMental Health Code: SMI HARM HIST NONE
Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provider Initials
2/14/06	ppd. 15mm			W
7/17/06	umbilical Hernia			Bo
8/17/06	Boil			W

**If Asthmatic label: Mild – Moderate – or Severe.

PRISON HEALTH SERVICES

Physician's Chronic Care Clinic

Date: 7/20/06 Time: _____ Facility: Kilby Correctional Facility

Check all applicable CIC's being evaluated: Card/HTN DM GI ID PUL SZ TB

SUBJECTIVE:

OBJECTIVE: BP 116/74 HR 72 RR 16 Temp 97.9 Wt 192 Peak Flow 750 L/min

NOTE: PE findings for CIC patients should be disease-specific and focused on prevention of end-organ Complications: DM-eye ground, skin, cardiopulmonary, extremities; HTN/Card-eye grounds, Cardiopulmonary, abdomen, extremities; ID-all systems; PUL-HEENT, Cardiopulmonary, A/P ratio; SZ-HEENT, neurological; GI-abdomen.

1) @ PPD, @ CCA

No C/O
INH since 7/06
LFT's 7/06 OK.
Lungs clear.

INH 300 mg P.O. QD
Vit. B₆ 25 mg P.O. QD

ASSESSMENT: Circle the appropriate Degree of Control and Status for each clinic monitored during today's Visit. Degree of Control: G=Good, F=Fair, P=Poor
Status: I=Improved, S=Stable, W=Worsened

DM			HTN/CARD			SZ			PUL			ID			GI			OTHER		
Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control			Degree of Control		
G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P	G	F	P
Status			Status			Status			Status			Status			Status			Status		
I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W	I	S	W

PLAN: 1) 9 AM INH

F/U: Routine 90 days: ☒ Other _____ Problem List Updated: Yes No

[Signature]

Physician/NP/PA

Nelson, Marvin
NAME

male
GENDER

B / W
RACE

14/669
AIS#
[REDACTED]
DOB

DEPARTMENT OF CORRECTIONS

NURSE'S

TB CHRONIC CARE CLINIC

S: CHRONIC CARE CLINIC			TB CHRONIC CARE CLINIC		ALLERGIES	
DATE/TIME 7/21/07 @ 0750					N/A	
O: VS T 97.9 P 72 R 16						
BP 116/74 WT 192.75% WT CHANGE			Y		(N)	
Date PPD done 7/14/07						
Results in MM 15 mm						
Last CXR Date 7/18/07						
Results SEE CXR report						
Cough			Y		(N)	
Sputum production			Y		(N)	
Description			Y		(N)	
AFB + Smear			Y		(N)	
HIV test (date) 7/4/07 - NK			Y		(N)	
Lung fields Clear			Y		(N)	
Nausea—Vomiting—Fatigue			Y		(N)	
Loss of appetite			Y		(N)	
Smoke			Y		(N)	
Review of FLU shot date			Y		(N)	
Review of Pneumovax date Unavailable			Y		(N)	
Medication compliant			Y		(N)	
Education Done			Y		(N)	
Topic:			Y		(N)	
Recently admitted to hospital/infirmiry			Y		(N)	
Update TB Summary Record			Y		(N)	
NOTES: continue to encourage med compliance for 9 mos as prescribed.						
INMATE NAME			NUMBER		AGE	
Nation, Marvin			141669		40	
RACE/SEX			W/M		p Man Nation	
CCC WITH NURSE (order)			1 2 3 Months		SIGNATURE	
CCC WITH MD EVERY (order)			1 2 3 4 5 6 Months			

CHRONIC CARE CLINIC
REFERRAL FORM

REFERRAL DATE: 7-17-06

REFERRING DEPT: P.E.

NAME OF PATIENT: Nativ, Maria

AIS# 141669 DOB: [REDACTED] RACE: B W

CLINIC: TB

MEDICATIONS: INH 300 mg p.o. QD
Vit. B6 25 mg p.o. QD

COMMENTS:

DATE SEEN IN CLINIC: 7/26/06

IMMUNIZATION RECORD

Name Nation, Marlene AIS 41669 D.O.B. [REDACTED]

Hep A Vaccine

Date _____ By _____

Date _____ By _____

Hep B Vaccine

1) Date _____ By _____

2) Date _____ By _____

3) Date _____ By _____

Influenza

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

Pneumococcal

Date _____ By _____

Date _____ By _____

Date _____ By _____

Date _____ By _____

TB PPD

Date 7-17-6 Result 15mm

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Date _____ Result _____

Tetanus Date _____ By _____

Tetanus Date _____ By _____

INTAKE HEALTH EVALUATION

NAME: Nation Marvin
 AIS #: 147669
 D.O.B.: [REDACTED]

R.N. evaluation within 24 hours.

Age 40 Sex M Race W Height 6'1" Weight 198

Temp: 97.6 B/P: 120/70 Pulse: 70 Resp: 20

** B/P - If greater than 140/90, repeat in 1 hour. Refer to Mid-Level if B/P remains up.

Do you now or have you ever had, or been treated for:

Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gastritis <u>Abd. surg.</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS ***	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Loss of Consciousness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	***Medications Verified	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Bleeding	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Hepatitis - Type	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vertigo/Dizziness	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gall Bladder/Pancreas	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Liver Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lice, Crabs, Scabies	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Seizures	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Joint Muscle Problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	LMP	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Back/Neck Problem	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Date	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Disorders	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Kidney Stones/Dz	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Duration	<input type="checkbox"/>	<input type="checkbox"/>
DT's	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Bladder/Kidney Infection	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Normal	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Regularity	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Heart Attack	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Gravida/Para	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Psychiatric History	<input type="checkbox"/>	<input checked="" type="checkbox"/>	AB/Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood Disorder	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Suicidal Thoughts**	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Contraception	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell or Trait	<input type="checkbox"/>	<input checked="" type="checkbox"/>	**Immediate M.H. Referral	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Type:	<input type="checkbox"/>	<input type="checkbox"/>
Lung Condition	<input type="checkbox"/>	<input checked="" type="checkbox"/>	T.B.	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Asthma *	<input type="checkbox"/>	<input checked="" type="checkbox"/>	PPD - date given: <u>7/4/6</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
*Peak Flow Reading	<input type="checkbox"/>	<input checked="" type="checkbox"/>	RFA/LFA	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Lab Tests - Dates	N	Ab
Bronchitis	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Date read: <u>7-15-6</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Diagnostic Profile II	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Results: <u>15</u> mm	<input type="checkbox"/>	<input checked="" type="checkbox"/>	RPR	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Visual Acuity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Urine Dip Stick	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>00/00</u> <u>00/00</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever/Allergies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<u>00/00</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	EKG (@ age 35)	<input type="checkbox"/>	<input type="checkbox"/>

Immunization History: _____

***HIV Medications: _____

Acute or Chronic Problem Noted: Y ☐ N ☒ Refer to Mid-Level or M.D. if yes.

[Signature]
 RN or Mid-Level, Signature

7/18/06 8:00
 Date/Time

NAME: _____

AIS#: _____

D.O.B.: _____

R/S _____

HEALTH CLASSIFICATIONS:
(Circle One)

1 - No Restrictions

(2) - Temporary Restrictions
See Special Needs Form

3 - Permanent Restrictions
See Special Needs Form

4 - A&I (Aged & Infirm)

5 - Not Determined
Recheck _____

PLACEMENT:

General Population ☒
Emergency Department ☐
Isolation ☐
Medical Observation ☐
Other _____

REFERRAL:

CCC Placement ☐

Clinic(s) _____
See MD/Mid-Level flow sheet
for clinic(s).

Medical ☐
Dental ☐
Mental Health ☐
Other _____

When: ☐ Immediately
☐ Next Sick Call

IMMUNIZATIONS ORDERED:

Medications Ordered: _____

- 1) Umbilical Hernia
- Abd. binder
- BB / x lift profiles
- Motrin PRN
- Flu 3mes / PRN

APPRAISAL	N	Abn/Comment
General Movement Deformity Pain, Bleeding Habit, Hygiene	<input checked="" type="checkbox"/>	
Neuro Mental Status Intox Withdrawal Tremor Neuro-Deficits	<input checked="" type="checkbox"/>	
Skin Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions Infestations Needle Marks Color, Turgor	<input checked="" type="checkbox"/>	T = abd
Head Normocaphalic Atraumatic Hair, Scalp	<input checked="" type="checkbox"/>	
Eyes Glasses/Vision Pupils Sclera, Conjunctiva	<input checked="" type="checkbox"/>	
Ears Appearance Canals, TMs, Hearing	<input checked="" type="checkbox"/>	
Nose Epistaxis Sinuses	<input checked="" type="checkbox"/>	
Throat Teeth, Gums, Dentures Mouth, Tongue Tonsils Airway	<input checked="" type="checkbox"/>	
Neck C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	<input checked="" type="checkbox"/>	
Chest Config Ausc/Resp Cough/Sputum Breast/Masses	<input checked="" type="checkbox"/>	
Heart Ausc Rate, Rhythm Murmurs, Ectopy	<input checked="" type="checkbox"/>	
Abdomen Bowel Sounds Palp, G/R/T, Hernia	<input checked="" type="checkbox"/>	Umbilical hernia ulcers
GU Flank Tenderness Bladder Tenderness/Distention	<input checked="" type="checkbox"/>	
Back ROM, Spasm, Injury	<input checked="" type="checkbox"/>	
Extremities Edema, Pulse	<input checked="" type="checkbox"/>	
Genitals Injuries/Lesions	<input checked="" type="checkbox"/>	
Pelvic Pap	<input checked="" type="checkbox"/>	
Rectal/Guicac (required @ 45 and up) Deferred/follow-up:	<input checked="" type="checkbox"/>	

M.D. or Mid-Level Signature

Date/Time

[Signature]

7/17/06

I have read the *access to health care* information sheets and have been given a copy I understand how to access health care

Name Marvin Nation Date 7-18-06

AIS# 141669

Medical Staff J Thomas CNA Date 7-17-06

POSITIVE TB SKIN TEST

You have tested positive for tuberculosis. This screening test does not mean you have TB. It just means that at some time in your life you have been exposed to the TB bacteria.

You will be given a chest x-ray.

If you have never had a prior positive skin test and have never been on preventive medication then you will begin medication.

You will be placed on INH 300mg and vitamin B6 daily. These will be taken for nine months. This medication is prescribed for prevention of active tuberculosis.

It is your responsibility to go to population pill call daily at 9:00am for your medication.

If you are released prior to the completion of nine-month therapy you are expected to go to the County Health Department for medication. It is a violation of probation not to complete the nine-month therapy.

Once the treatment is complete, always inform medical personnel that you have tested positive for screening TB skin test and have been treated.

The side effects of the medication are rare. If you have any problems, please sign up for sick call.

Marvin Naton
INMATE SIGNATURE

7-17-06
DATE

141669
INMATE AIS#

Rhy
WITNESS SIGNATURE

7-17-06
DATE



PRISON
HEALTH
SERVICES
INCORPORATED

T.B. SCREENING FORM

Skin Test Positive Date 7-17-6 15 mm Today's Date 7-17-6

Any Symptoms of:

Yes

No

Loss of Appetite

☒

Fever/Chills

☒

Hoarseness

☒

Chest Pain

☒

Weight Loss

☒

Usual Weight 192

Present Weight 192

Night Sweats

☒

Excessive Fatigue

☒

Dyspnea

☒

Productive Cough (more than 3 weeks)

☒

IF YES:

Sputum Production _____ Color _____

Consistency _____

Hemoptysis _____

HIV Positive _____

Nurse Signature [Signature] Date 7-17-6

*Refer to MD or Mid-Level Provider if any YES answers.

INMATE NAME	AIS #	D.O.B.	FACILITY
<u>Nation Mawon</u>	<u>141669</u>	<u>[REDACTED]</u>	<u>KCF</u>



INTAKE SCREENING

Date: <u>7/14/06</u>	AIS#: <u>191669</u>	
Last Name: <u>Nation</u>	First: <u>Marvin</u>	Middle: <u>Kurt</u>
Birthplace:	DOB: <u>[REDACTED]</u>	SS#: <u>[REDACTED]</u>

FEMALES: Pregnancy test: (circle one) Positive <u>_____</u> Negative <u>_____</u>	B/P <u>132/74</u> Temp <u>98</u> Pulse <u>72</u> Resp. <u>16</u> Weight <u>192</u> FSBS <u>109</u> If level > 200, repeat within 48 hours. Above 300 call M.D.
--	---

Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where?

umbilical hernia

Previous Incarcerations (Date & Facility)

2005 - Hackley

Medications: <input checked="" type="checkbox"/> None	Special Diet (Prescribed)
Allergies: <input checked="" type="checkbox"/> NKA	Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) NO <u>_____</u>

ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE

CLINICAL OBSERVATIONS

1) Level of Consciousness: () Alert () Oriented; time, place, person () Lethargic () Stuporous () Comatose Describe:	3) Substance Abuse: () Yes () No () Suspected () Current intoxication/Abuse () Use () Withdrawal Symptoms () Drugs () Alcohol Describe: What kind? Amount/Frequency? <u>Mar - 2005 - 2 yrs</u> • If confirmed Benzo use then call M.D. If can not be confirmed call M.D. Last Use: (Time/Date): <u>7/2 days</u>
2) General Appearance () Normal () Abnormal	4b) Affect/Mood: () Normal () Manic () Depressed () Euphoria () Flat () Emotionally Confused Describe:
3) Signs of Trauma () Yes () No	4c) Perceptions: () Delusional () Hallucinations () Hearing Voices <u>N/A</u>
4a) Behavior/Conduct: () Calm () Cooperative () Non-Violent () Agitated () Uncooperative () Violent () Manipulative () Disorganized Describe:	5b) Does pt describe current suicidal thoughts or ideations? () Yes () No <u>_____</u> 5d) High risk pt may become assaultive towards staff? () Yes () No <u>_____</u>
5a) Is there h/o actual suicide attempt? () Yes () No <u>_____</u> 5c) Is there evidence	Triggers for Suicide Watch - Currently Suicidal - History of actual attempt - Fails to maintain control on Close Watch Y or N
If ANY of the above in #5 are circled staff MUST describe here, include previous history and dates: *Any abnormal observations #4 or 5 require immediate Mental Health Referral	Triggers for Close Watch - Emotionally distraught and unable to regain composure by end of intake process - Actively hallucinating or not making any sense Y or N

6a) Communication Difficulties () Yes () No <u>_____</u>	6b) Memory Defects () Yes () No <u>_____</u>
6c) Hearing Impairment () Yes () No <u>_____</u>	6d) Speech Difficulties () Yes () No <u>_____</u>
7) Physical Aids: () None () Glasses () Contacts () Hearing Aid () Dentures () Cane () Crutches () Walker () Wheelchair () Braces () Artificial Limb () Other	

8) Additional comments complaints symptoms: <u>None</u>
S)
O) Fever Y N Swollen Glands Y N Signs of Infection Y N Skin Intact Y N
A)
P)

If known Diabetic * Call M.D. for order Initial Insulin given:

I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for health services to be provided to me by and through PRISON HEALTH SERVICES.

Marvin Nation 7-14-06 Inmate's Signature/Date
[Signature] Health Provider Signature/Date



PRISON HEALTH SERVICES, INC.

DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

Trudy Nation mother
Name Relationship

116 Delwood St. 334-598-3135
Street Address Phone Number

Daleville Al. 36322
City State Zip Code

Mary Nation 41669 [REDACTED] 7-14-06
Inmate Signature AIS# SS# Date

Witness Date

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	D.O.B.	RACE/SEX	FACILITY



PRISON HEALTH SERVICES, INC.

DEPARTMENT OF CORRECTIONS

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Street Address Phone Number

Daleville Al. 36322
City State Zip Code

Mary Nation 14669 [REDACTED] 7-14-06
Inmate Signature AIS# SS# Date

Witness Date

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	DOB	RACE/SEX	FACILITY

ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary, for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems
(adjustment to prison, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonably clear risk of escape or creation of institutional disorder
- Receiving psychotropic medication
- Require movement to a special unit or cell for observation and treatment
- Require transfer to a psychiatric hospital outside of the prison
- Require a new program assignment for mental health, medical or security reasons

Mental health staff have a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access to your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigative staff and legal counsel working with the ALDOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

The information on this form has been explained to me and I have received a copy of this information for my future reference

Morison Nation
Inmate Signature

1444
AIS Number

8-7-06
Date Signed

ALDOC Form 451-01

STATE OF ALABAMA
DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES

Psychological Evaluation

Name: Dutton, Marvin AIS# 1416691 R/S W/m

Date: 8/7/06 Date of Birth: [REDACTED] Age: 40

Beta III: 90 (A) WAIS: 1 / 1 WRAT-RL: 4.2

Last School Grade Completed: 11 Special Education Classes: ☐ Yes ☒ No Type: _____

MMPI Welsh Code: Not given

Mental Health Code: (0) 1 2 3 4 5 6

General Appearance

- ☒ a. Neat and generally appropriate ☐ c. Flat or avoiding interaction
☐ b. Poorly groomed ☐ d. Sad or worried

Other: _____

I. Interpersonal Functioning

- ☐ a. Normal-good relationships likely
☐ b. Withdrawn/apparent loner
☒ c. Likely to ignore rights/needs
☐ d. Lacks skill or confidence
☐ e. Probably difficult to get along with

f. other

- ☐ 1. Exploitive/manipulative
☐ 2. Weak/vulnerable
☐ 3. Passive/unassertive
☐ 4. Aggressive/Dominant
☐ 5. Retaliates
☐ 6. _____

II. Personality

- ☐ a. Healthy
☒ b. Antisocial
☐ c. Paranoid
☐ d. Explosive
☐ e. Dependent
☐ f. Passive-Aggressive

g. other

- ☐ 1. Schizoid ☐ 7. Compulsive
☐ 2. Schizotypal ☐ 8. Atypical/mix
☐ 3. Histrionic ☐ 9. _____
☐ 4. Narcissistic ☐ 5. Borderline
☐ 6. Avoidant

III. Substance Abuse

a. Alcohol addiction/abuse history: _____

b. Drug addiction/abuse history: marijuana w/ 1st

use approx 9 months ago -
pt (1) - minimized use

Name: Nicholsc. Current or most recent use: Deniald. Current Addictions: Denial

e. Other:

1. In remission 6 months or less

2. In remission more than one year

3. In remission more than one year

4. In remission only due to incarceration

☒ 5. Drug use/denies dependency

6. Alcohol use/denies dependency

7. OBS-drug/alcohol induced

8. Other: _____

IV. Emotional Status

a. No significant problems

b. Depressed

c. Anxious or stressful

d. Angry or resentful

e. Confusion or psychotic symptoms

f. Mood disturbances

g. Sexual maladjustment

History of sex offenses? ☐ Yes ☒ No List: _____

h. Paranoid ideation

i. Sleep/appetite disorder NO problems

j. Other

1. Symptoms of Hypochondria

2. Hyperactivity

3. Violent/uncontrolled

4. Overly psychotic

5. Psychosis in remission

☒ 6. Personality disorder

7. Behavior disorder

8. Senile/demented

9 Other

Name: Norton**V. Mental Deficiency**

☐ Mild (50-70)
☐ Moderate (35-50)
☐ Severe (20-35)

☐ Borderline (70-80)
☐ Organic impairment suspected
☐ Memory Deficit

Remarks: IQ 90**Emotional response to incarceration:****VI. Mental Health**

a. Outpatient treatment (dates/where)

b. Inpatient treatment (dates/where)

c. Psychotropic medication (type/effectiveness)

d. Family history of mental illness

VII. Management Problemsa. Suicide potential Ideation ☐ Yes ☒ No Plans? ☐ Yes ☒ No

History of attempt/gestures

b. Serious mental illness (specify)

c. Impulsive/acting-out behaviors predicted

d. Authority Conflict

e. Manipulative/untrustworthy He can't tell the truth - he would not knowf. Easily victimized how

FOUNTAIN CORRECTIONAL CENTER

I have received *access to health care* information I understand how to access health care
and I understand the grievance process.

Marvin Nation 141669
Patient Name AIS Number

8-12-06
Date

M. Barb, Jr
PHS Staff

8-12-06
Date



SPECIAL NEEDS COMMUNICATION FORM

Date: 7-19-6To: ADOCFrom: PEInmate Name: Nation, Marvin ID#: 141669

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions Φ Straining / Φ lift greater than 20 lbs ^{X180d}
4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Bone profile X180d

/ / /

Date: 7/17/6 MD Signature: Aden Corp / Rg Time: 1:30

7/19/64
MD

60418

RECEIVING SCREENING FORM

INMATE'S NAME: Nation, Marvin DATE: 7/14/06 TIME: 9:10amDOB: [REDACTED] OFFICER: Col Hiles INSTITUTION: KILBYRECEIVING OFFICER'S VISUAL OPINION

	YES	NO
Is the inmate conscious?	<u>8</u>	<u> </u>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<u> </u>	<u> </u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<u> </u>	<u> </u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<u> </u>	<u> </u>
Is the skin in poor condition or show signs of vermin or rashes?	<u> </u>	<u> </u>
Does the inmate appear to be under the influence of alcohol, or drugs?	<u> </u>	<u> </u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	<u> </u>	<u> </u>
Is the inmate making any verbal threats to staff or other inmates?	<u> </u>	<u> </u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<u> </u>	<u> </u>
Does the inmate have any obvious physical handicaps?	<u> </u>	<u> </u>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was 6 a. Released for normal processing

 b. Referred to health care unit

 c. Immediately sent to the health care unit.

Col Hiles
Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards

FOUNTAIN CORRECTIONAL CENTER

I have received *access to health care* information. I understand how to access health care
and I understand the grievance process.

Marvin Nation 141669
Patient Name AIS Number

8-12-06
Date

M. Barb, Jr
PHS Staff

8-12-06
Date



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The following action is recommended for medical reasons:

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4. May have extra _____ until _____
5. Other _____

Comments:

Bottom Burr profile X180d

/

/

/

Date: 7/17/6 MD Signature: Aden Carr / Ray Time: 1:30

7/19/64
MD

RECEIVING SCREENING FORMINMATE'S NAME: Nation, Marvin DATE: 7/14/06 TIME: 9:10aDOB: [REDACTED] OFFICER: Col Hives INSTITUTION: KILBY**RECEIVING OFFICER'S VISUAL OPINION**

	YES	NO
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FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was 6 a. Released for normal processing

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 c. Immediately sent to the health care unit

Col Hives

Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCCH Standards.



DEPARTMENT OF CORRECTIONS TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: Loxley WR

Date: _____ Time: _____ AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

Elmore
 RECEIVING MEDICAL STATUS
☒ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: ElmoreDate: 3/29/05 Time: 12:00 AM/PM

RELEASE FROM:

☐ Infirmary ☐ Segregation☒ Population ☐ Mental Health☐ Other _____

RELEASE TO:

☐ DOC ☒ Infirmary ☐ Mental Health☐ _____

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

NKA

PHYSICAL EXAMINATION

Date of last exam: 5/25/04Chest X-Ray Date: 5/27/04 Result: ØPPD Reading 5/27/04 Ø

Classification: _____

Limitations: _____

LAB RESULTS - - LAST REPORT

CBC

Urinalysis

 Date
9/24/04
4/16/02

Normal

Abnormal

☒☒☐☐Wears Glasses/Contacts ☐Dental Prosthesis ☐Hearing Aide ☐Other Prosthesis ☐

YES

NO

☐☐☐☐☒☒☒☒B. Hall LPN
Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS

☐ Sent w / inmate☐ Not sent w / inmate

X-RAY FILM

☐ Sent w / inmate☒ Not sent w / inmate

HEALTH RECORD

☒ Sent w / inmate☐ Not sent w / inmate

Released to: _____

Date: _____ Time: _____ AM/PM

MEDICATIONS

☐ Received☐ Not Received

X-RAY FILM

☐ Received☒ Not Received

HEALTH RECORD

☐ Received☐ Not Received

CHART REVIEWED

☒ YES☐ NOReceived by: B. Hall LPN

Signature of Receiving Nurse

Date: _____ Time: _____ AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

FOLLOW-UP CARE NEEDED

☐ Medical ☐ Dental☐ Mental Health

Date

Time

With Whom - - Location (Sending Nurse)

Date/Appt. Made w/Whom (Rec Nurse)

 NURSING ASSESSMENT (SENDING NURSE)
 (Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use		
Mental Illness		
Suicide Attempt		
Chronic Care		

STATUS		
Special Diet		
Appearance		

OTHER PERTINENT NURSING ASSESSMENT

 NURSING ASSESSMENT (RECEIVING NURSE)
 (Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores		
Lice		
Edema		
Warm & Dry		
Cool & Moist		

CONDITION		
Alert		
Oriented		
Uncooperative		
Depressed		

INTAKE

Sick Call Procedures Explained yesHeight 6'1"Weight 200#Blood Pressure 100/70Temperature 97.6Pulse Resp 68-20

Other _____

Signature of Nurse Completing Assessment (Sending Nurse)

INMATE NAME (LAST, FIRST, MIDDLE)

Nation, Marvin

Date

Signature of Intake Screening Nurse (Receiving Nurse)

DOC# 141669DOB [REDACTED]Race/Sex WMFAC. Elmore



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: MARVIN K NATION Date of Request: 10-12-04
 ID # 141669 Date of Birth: [REDACTED] Location: C-126
 Nature of problem or request: I need to see The Doctor, my left eye is still hurting AND my NOSE is Fracture OR Broke and the Left side of my face is starting to Swell up again.

Marvin Nation
Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/14/04
 Time: 7:50 AM PM
 Allergies: NKA

RECEIVED

Date: _____
 Time: _____
 Receiving Nurse Initials _____

(S)ubjective: "I can't breathe out of my left nose and I am having headache and I was suppose to have nasal spray and dental wax"

(O)bjective (V/S): T: 96⁴ P: 76 R: 18 BP: 112/72 WT: _____
Has braces to upper and lower teeth to pain to head and unable to breath from (L) nose. requesting dental wax for braces.
 (A)ssessment: Alteration in Health Maintenance

(P)lan: HCP to review inmate given instruction on Braces and post MVA pain

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE ☒ EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

[Signature]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PHYSICIANS' ORDERS

NAME:

DIAGNOSIS (If Chg'd)

D.O.B. / /

ALLERGIES:

Use Last Date / /

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Nation, Marvin

DIAGNOSIS (If Chg'd)

D.O.B. [REDACTED]

ALLERGIES: NWA

Use Fourth Date 11/4/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Nation, Marvin

DIAGNOSIS (If Chg'd)

D.O.B. [REDACTED]

ALLERGIES:

Use Third Date 10/20/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: Nation, Marvin

DIAGNOSIS (If Chg'd)

D.O.B. [REDACTED]

ALLERGIES:

Use Second Date 10/20/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED

NAME: NATION MARTIN

DIAGNOSIS

D.O.B. [REDACTED]

ALLERGIES:

Use First Date 9/23/04

☐ GENERIC SUBSTITUTION IS NOT PERMITTED



PHYSICIANS' ORDERS

NAME: Naton, Marvin 141669 D.O.B. [REDACTED] ALLERGIES: Use Last Date 10/7/04	DIAGNOSIS (If Chg'd) See below No lifting greater than 10 lbs X 4 wks Peanut Butter Sandwich @ hs X 3 wks Dyspnoeic pain med orders Light duty X 4 weeks - Noted 10/10/04 3:15 <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Naton, Marvin 141669 D.O.B. [REDACTED] ALLERGIES: PKA Use Fourth Date 10/7/04	DIAGNOSIS (If Chg'd) See above Motrin 600mg $\dot{\bar{e}}$ prn $\dot{\bar{e}}$ po TID X 14 days Amoxicillin 500mg $\dot{\bar{e}}$ po for 4 more days (has card) Soft diet till further notice BBP X 4 wks No prolonged standing X 30 mins X 4 wks <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Naton, Marvin 10/4/04 0746 D.O.B. / / ALLERGIES: Use Third Date / /	DIAGNOSIS (If Chg'd) 1) Soft diet. <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Naton, Marvin #141669 D.O.B. [REDACTED] ALLERGIES: NKA Use Second Date 9/26/04	DIAGNOSIS (If Chg'd) 1) Hydrocodone/acetaminophen 10mg po q 4 th prn X 30cl. 2) Surgery plan $\dot{\bar{e}}$ Dr. Keane OK 3) May $\dot{\bar{e}}$ for back to prison facility (infirmery) 4) Keep hand chart until he goes <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: Naton, Marvin #141669 D.O.B. [REDACTED] ALLERGIES: NKA First Date 9/26/04	DIAGNOSIS Saline Rinses PRN Ensure TID $\dot{\bar{e}}$ meals Vicodin 5/500mg $\dot{\bar{e}}$ po q 4 th prn pain X 10 Amoxicillin 500mg $\dot{\bar{e}}$ po TID X 1 wk V.D. Mr. Rehman / Rhyt <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY



PHYSICIANS' ORDERS

NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Last Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Fourth Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Third Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME:	DIAGNOSIS (If Chg'd)
D.O.B. / /	
ALLERGIES:	
Use Second Date / /	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED
NAME: <i>Elmore, Vation, Mann</i>	DIAGNOSIS <i>acute Rt naris furuncul</i>
<i>14/669</i>	<i>Tylenol II PR BID per pain x 4 days</i>
D.O.B. <i>[redacted]</i>	<i>Bachman DS BID x 10 days</i>
ALLERGIES: <i>NKA</i>	<i>perampun 300mg</i>
Use First Date <i>3/30/04</i>	<i>Warm ES work Rt naris T/day x 3</i>
	<i>Meds 600mg BID per pain x 4 days</i>
	<input type="checkbox"/> GENERIC SUBSTITUTION IS <u>NOT</u> PERMITTED

MEDICAL RECORDS COPY



PHYSICIANS' ORDERS

NAME: <i>Nation, Marvin</i> 141669 D.O.B. [REDACTED] ALLERGIES: Use Last Date 9/22/04	DIAGNOSIS (If Chg'd) <i>Vico dinitro 100 mg po q 4-6 hr pain x 7d</i> <i>per Vico Dr. W. Williams</i> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: <i>Nation, Marvin</i> 141669 D.O.B. [REDACTED] ALLERGIES: <i>NKA</i> Use Fourth Date 9/22/04	DIAGNOSIS (If Chg'd) <i>1st dose given 1650</i> <i>give two percocet 4-6 hr prn pain q 4-6 hr</i> <i>give with 650 Tylenol for 7 days</i> <i>give Tylenol #3 for breakthrough pain q 6 hr prn - for 7 days</i> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: <i>Nation, Marvin</i> 141669 D.O.B. [REDACTED] ALLERGIES: Use Third Date 9/22/04	DIAGNOSIS (If Chg'd) <i>Make sure tetanus UTD</i> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: <i>Nation, Marvin</i> 141669 D.O.B. [REDACTED] ALLERGIES: Use Second Date 9/22/04	DIAGNOSIS (If Chg'd) <i>Amoxicillin 500mg po TID x 7 days</i> <i>mouth admission till p surgery</i> <i>Liquid diet till p surgery or soft diet</i> <i>X-ray facial series</i> <i>Dressing change q 4-6 hr x 7 days</i> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED
NAME: <i>Nation, Marvin</i> 141669 D.O.B. [REDACTED] ALLERGIES: Use First Date 9/22/04	DIAGNOSIS <i>Tylenol #3 4 po q 4-6 hr prn x 7d</i> <input type="checkbox"/> GENERIC SUBSTITUTION IS NOT PERMITTED

MEDICAL RECORDS COPY



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: MARVIN NATION Date of Request: 10-23-04
 ID # 141669 Date of Birth: [REDACTED] Location: A-1-100
 Nature of problem or request: I need to see the Doctor About
my BACK pain AND ALSO I've been HAVING REAL
BAD Head Aches.

Thank you
Marvin Nation
 Signature

DO NOT WRITE BELOW THIS LINE

Date: 10/26/04
 Time: 0700 AM PM
 Allergies: NKA

RECEIVED

Date: _____
 Time: _____
 Receiving Nurse Initials _____

(S)ubjective: Im getting bad H/A & pressure behind left
ear. & my back is still bothering me. sharp pain
runs up L side of back about 8 inches.

(O)bjective (V/S): T: 97.4 P: 88 R: 20 BR: 120/88 WT: 18.5
Rom to back, painful L side of thoracic, posterior
cap. Heavy refil L3 sec. sm. smk. Facial Edema. History
of van wreck Sept. 21, 2004

(A)ssessment:

Attraction in Comp. back

(P)lan:

Ref review

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No () Has Had apt 11/4
 Was MD/PA on call notified: Yes () No ()

[Signature]
 SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

Last	First	Middle Initial	Name	AIS #
Date	Allergies		Facility	
SIG.			Discontinue	
			Continue	
			Increase	
Physician Signature:			Decrease	

NC002

Last	First	Middle Initial	Name	AIS #
Date	Allergies		Facility	
SIG.			Discontinue	
			Continue	
			Increase	
Physician Signature:			Decrease	

NC002

Last	First	Middle Initial	Name	AIS #
Date	Allergies		Facility	
SIG.			Discontinue	
			Continue	
			Increase	
Physician Signature:			Decrease	

NC002

Last	First	Middle Initial	Name	AIS #
Date	Allergies		Facility	
SIG.			Discontinue	
			Continue	
			Increase	
Physician Signature:			Decrease	

NC002

Name	Last <u>Nation</u> First <u>Marrin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>7/3/03</u> Allergies <u>NKDA</u>	Facility <u>LCF</u>
SIG	<u>Motrin 600mg po TID PRN X5d</u>	Discontinue Continue Increase Decrease
Physician Signature: <u>V. Dr. Dancy</u>		NC002

Name	Last <u>Nation</u> First <u>Marrin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>3/15/03</u> Allergies <u>NKDA</u>	Facility <u>LCF</u>
SIG	<u>Amox 500 po TID X10d</u> <u>Ibuprofen 650 po TID X10d</u> <u>Proxophed - po BID X10d</u>	Discontinue Continue Increase Decrease
Physician Signature: <u>V. Dr. Simon</u>		NC002

Name	Last <u>Nation</u> First <u>Marrin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>11/13/02</u> Allergies <u>NKDA</u>	Facility <u>LCF</u>
SIG	<u>Motrin 800mg tid X 7d</u>	Discontinue Continue Increase Decrease
Physician Signature: <u>V. Dr. Camp</u>		NC002

Name	Last <u>Nation</u> First <u>Marrin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>8-7-02</u> Allergies <u>NKDA</u>	Facility <u>State</u>
SIG	<u>Selsun 30mg po + body wash</u> <u>BID X 14 XOP</u>	Discontinue Continue Increase Decrease
Physician Signature: <u>B. Hester</u>		NC002

Name	Last <u>Nation</u> First <u>Marvin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>7-9-02</u> Allergies <u>NKA</u>	Facility <u>St. Louis</u>
SIG.	<p><u>Linear function test then start</u></p> <p><u>Nizoral 200mg po qd x 7 d</u></p> <p><u>they are normal</u></p>	Discontinue Continue Increase Decrease
Physician Signature: <u>B. Helms</u>		

NC002

Name	Last <u>Nation</u> First <u>Marvin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>7-9-02</u> Allergies <u>NKA</u>	Facility <u>St. Louis</u>
SIG.	<p><u>Cont Anti-fungal cream / Powder TID</u></p> <p><u>Pris-Peg 330 qd x 14-DC</u></p>	Discontinue Continue Increase Decrease
Physician Signature: <u>B. Helms</u>		

NC002

Name	Last <u>NATION</u> First <u>MARVIN</u> Middle Initial	AIS # <u>141669</u>
Date	<u>7-5-02</u> Allergies <u>NKA</u>	Facility <u>St. Louis</u>
SIG.	<p><u>antifungal cream apply TID to</u></p> <p><u>lash K.O.P. Given 7/5/02</u></p> <p><u>* Seen M.D. Tuesday 7/8/02</u></p>	Discontinue Continue Increase Decrease
Physician Signature: <u>Dr. Taylor / J. Cooper</u>		

NC002

Name	Last <u>Nation</u> First <u>Marvin</u> Middle Initial	AIS # <u>141669</u>
Date	<u>4/15/02</u> Allergies	Facility <u>Kilby</u>
SIG.	<p><u>Motrin 600mg: bid x 5 days</u></p> <p><u>to Dr. Anderson / E. Brady</u></p>	Discontinue Continue Increase Decrease
Physician Signature:		<p><u>noted</u></p> <p><u>mbw</u></p> <p><u>4/15/02</u></p> <p><u>162</u></p>

NC002

Location	ID#	Allergies

NAME _____	AIS# _____
DATE _____	FACILITY _____
SIG. _____	DISCONTINUE
	CONTINUE
	INCREASE
Physician Signature: _____	DECREASE

NAME _____	AIS# _____
DATE _____	FACILITY _____
SIG. _____	DISCONTINUE
	CONTINUE
	INCREASE
Physician Signature: _____	DECREASE

NAME _____	AIS# _____
DATE _____	FACILITY _____
SIG. <i>Admit to Westward BED #12</i>	DISCONTINUE
	CONTINUE
	INCREASE
Physician Signature: _____	DECREASE

NAME <i>Nation, Marvin</i>	AIS# <i>141669</i>
DATE <i>9/3/98</i>	FACILITY <i>Kelby</i>
SIG. <i>UA</i>	DISCONTINUE
<i>Amylase & lipase</i>	CONTINUE
	INCREASE
Physician Signature: <i>[Signature]</i>	DECREASE

NAME _____	DISCONTINUE
DATE _____	CONTINUE
SIG _____	INCREASE
Physician Signature: _____	DECREASE

NAME <u>Nation, Marvin</u>	DISCONTINUE
DATE <u>9-30-98</u>	CONTINUE
SIG <u>Motin 600mg bid x 3 day</u>	INCREASE
Physician Signature: <u>[Signature]</u>	DECREASE

NAME <u>Nation Marvin</u>	DISCONTINUE
DATE <u>9-9-98</u>	CONTINUE
SIG <u>Pancrase 40 po 30 mins before each meal</u>	INCREASE
Physician Signature: <u>[Signature]</u>	DECREASE

NAME <u>Nation, Marvin</u>	DISCONTINUE
DATE <u>9/7/98</u>	CONTINUE
SIG <u>Release to population</u>	INCREASE
Physician Signature: <u>[Signature]</u>	DECREASE

NAME <u>Nation, Marvin</u>	AIS# <u>141663</u>
DATE <u>09/15/98</u>	FACILITY <u>KCF</u>
SIG. • D/C IV • D/C Tagamet 300mg IV	DISCONTINUE CONTINUE INCREASE DECREASE
Physician Signature: <u>T.O. De An / R. Burkette, MD</u>	

NAME <u>NATION, MARVIN</u>	AIS# <u>141669</u>
DATE <u>9/4/98</u>	FACILITY <u>KCF</u>
SIG. Paucrease 40 po 30mins before each meal x 30d	DISCONTINUE CONTINUE INCREASE DECREASE
Physician Signature: <u>T. Haneff</u>	

NAME <u>NATION, Marvin</u>	AIS# <u>141669</u>
DATE <u>9/4/98</u>	FACILITY <u>KCF</u>
SIG. Soft diet today & advance as tolerated	DISCONTINUE CONTINUE INCREASE DECREASE
Physician Signature: <u>T. Haneff</u>	

NAME <u>Nation, Marvin</u>	AIS# <u>141669</u>
DATE <u>9/3/98</u>	FACILITY <u>KCF</u>
SIG. Tagamet 300mg IV q12° Demerol 25mg IM x 5d 968° x 1d	DISCONTINUE CONTINUE INCREASE DECREASE
Physician Signature: <u>T. Haneff</u>	



PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST

Print Name: MARVIN NATION Date of Request: 5-27-04
 ID # 14669 Date of Birth: [REDACTED] Location: ECC
 Nature of problem or request: I was scheduled for a
Hernia operation on Dec. 15th of 2003 and
was supposed to be rescheduled, I haven't

Marvin Nation
Signature # 14669

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p align="center">RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

(O)bjective (V/S): T: _____ P: _____ R: _____ BP: _____ WT: _____

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Elmore

Print Name: MARVIN NATION Date of Request: 3-29-04
 ID # 141669 Date of Birth: [REDACTED] Location: C-1-103 Elmore
 Nature of problem or request: I have been bit by a spider or
I either have a staff infection inside my nose and
my hold nose is sore, I need to see a doctor

Thank you Marvin Nation
 Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date: <u>3-30-04</u>	<i>slc</i>
Time: <u>9:00</u>	
Receiving Nurse Initials <u>mg</u>	

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

*No show for
 sick call screening*

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE (☒) EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Justin [unclear]

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



HEALTH SERVICES REQUEST FORM

Print Name: MARVIN NATION Date of Request: 3-15-03

ID#: 141669 Date of Birth: [REDACTED] Housing Location: 6-13-28-T

Nature of problem or request: I have a cold my throat hurt
And my nose is running.

Marvin Nation
Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective: see above

Objective: BP 120/80 P 80 R 16 T 99.2

Assessment: cold -

Plan: Amox Drex
Tylenol ↑ Zlevol

Refer to: ☐ PA/Physician ☐ Mental Health ☐ Dental

Signature: [Signature] Title: OK 3/15/03 Date: 3/15/03 Time:

Haphcare

Health Services Request Form

Name MARVIN NATION 14/6/69 Date of Request Aug 6th, 02
14/6/69 Date of Birth [REDACTED] Housing Location D-2-17T
 e of problem or request I Steel have A fungus on my
BACK that will not go AWAY AN it is getting
worse

Marvin Nation 14/6/69

for consent to be treated by health staff for the condition described above.

Place this slip in Medical Box or designated area
 DO NOT WRITE BELOW THIS LINE

8-7-02

7
Bing also

Health Care Documentation

I got a fungus rash to my back that
 not getting better. Now the rash is itching

BP 120/70 P 80 R 20 T 96° W/180

Alert? Orient VB Report ease Scatter (several)
 circular rash noted to upper back varies in size
 redness & drainage. Rigid edges noted
 Alteration in skin integrity

MD to review a/c on 8/1/02 12:30A

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: MARVIN NATION Date of Request: 3/5/01
 ID #: 141669 Date of Birth: [REDACTED] Housing Location: N-47
 Nature of problem or request: Real BAD Back ~~problem~~ ^{prostate problem}
& my PANCREATITIS

I consent to be treated by health staff for the condition described.

Marvin Nation
SIGNATURE

**PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA**

HEALTH CARE DOCUMENTATION

Subjective: I almost slipped in the shower Sat Night & my back has been hurting every since.

Objective: BP 160 P 80 R 20 T 97.4
80

Assessment: clo back pain clo real bad pancreatitis (had stent put in duct part of pancreas)

Plan: Scheduled to see MD today

Refer to: ☒ PA/Physician ☐ Mental Health ☐ Dental

Signature: G. Burkette Title: LPN Date: 3/5/01 Time: _____

Date/Time	Inmate's Name:	D.O.B.:
9/23/04 2300	Nelson, Mauri	1 1
	<p>I need my pain medicine, please. My face is hurting - I can have a soft diet -</p> <p>O. Ambulatory in mch. Alut's oriented x3. Shown w/ D. Respire ease - Bruises contusions & @ face. Bandaid intact & urine @ lower leg & old bloody drainage to bandaid (dry).</p> <p>(A) alteration in comfort & skin integrity -</p> <p>(P) Admin pain med per MAR - monitor</p> <p>(E) Advised inmate he is not to eat or drink after midnight due to surgery on 9/24/04 - He varied understanding</p>	
2350	I Vicodin tabs it po adm for clo pain & face pain	
9/24/04 0300	<p>0030 - in bed 3 clo pain -</p> <p>Tylenol 650 mg & Percocet tabs it po adm for clo pain. All po meds given & sigs @ 1120. He is held 5 food or drink prior to surgery.</p>	
10/19/04 8 ⁰⁰ P	<p>Placed in mch for FWA 10/20/04 - 98.4 - 58-22 - 148/84 - informed of WFO & MD status</p>	
10/20/04 1 ⁰⁰ P	<p>1/5 - B/P 100/70 P-84 R-20 T-98' Wgt-187 lbs</p> <p>Back from Flu appt. OK to return to pop. #P See</p>	
11/4/04 wgt 182	<p>To see HCP: flu</p> <p>B/P 110/72 T 97.7 P 64 R 20 O2 Sat 95</p> <p>F/U facial trauma. Is feeling better. Still 40 facial numbness (R) Thoracic pain. + (R) hip pain</p> <p>(A) A&X3</p> <p>Spine inline NTP, (R) parathoracic muscle knotted/TTP</p> <p>(R) S2 TTP.</p>	

over next page

Nation



PROGRESS NOTES

Date/Time	Inmate's Name: <u>Nathan, Marvin</u> 141669	D.O.B.: <u>[REDACTED]</u>
10/4/04	<p>Note Cont</p> <p>A. X-Rays ordered 10/20 not done will reorder hip + L/S spine</p> <p>P. Pt has F/u c facial surgeon. Naproxen + Flexen Pt show stretches for his back</p> <p><i>DMK</i></p>	
11/13/04	<p>MD Appt VU</p> <p>wt 188 Sp 118/80 T 97.5 P 64 R O2 96</p> <p>PT HERE F/u facial fx & Back film Report.</p> <p>Pain in lower back better w/ conservative mgmt.</p> <p>X-Rays normal. Facial paresthesias persistent on (L) face & oral pharynx on (L). Nasal - obstructed (L) chronic 2° deviation of septum</p> <p>F/u UTM submitted. Pain in (L) face worse w/ cold weather. Advised to take tylenol/nasibid PR</p> <p>USS:</p> <p>HEENT & evidence of infection - Mild/mod</p> <p>Nasal septal deviation c obstructive</p> <p>Nasal edema. Facial sensation ↓</p> <p>oral pharynx & infected sensation ↓</p> <p>speaks well. Breathes well</p> <p>As: Facial trauma F/u c ENT @ school</p> <p>in 2-3 wks</p> <p>For general instr.</p> <p><i>Shyly</i></p>	

[illegible]



PROGRESS NOTES

Date/Time	Inmate's Name: <i>Notion, Marvin</i>	D.O.B.: <i>/ /</i>
<i>9/27/04</i> <i>0719</i>	<i>38 yo w.m S/P ORIF (L) cheek + upper jaw fxr, uncomplicated.</i> <i>PMHx (-).</i> <i>VSS. Afebrile. % post op pain, otherwise ok. Alert/oriented.</i> <i>Teeth wired, bruising (L) cheek, minimal swelling.</i> <i>Lungs clear.</i> <i>Heart RRR 3 (m).</i> <i>Abdomen soft & organomegaly/mass.</i> <i>Mild bruising + healing abrasion (L) medial lower leg.</i>	
	<i>A/P 1) S/P ORIF (L) facial fxr.</i> <i>Clinically stable.</i> <i>Surgery 7/11 soon.</i> <i>OK to return to prison facilities.</i>	
	<i>Robb</i>	
<i>9/28/04</i> <i>0650</i>	<i>VSS. Afebrile. No new %. No changes.</i>	
	<i>Robb</i>	
<i>9/29/04</i> <i>0645</i>	<i>VSS. Afebrile. No new %. No changes.</i>	
	<i>Robb</i>	
<i>10/1/04</i> <i>0711</i>	<i>VSS. Afebrile. No new %. No changes.</i>	
	<i>Robb</i>	

Date/Time	Inmate's Name:	D.O.B.: / /
09/24/04	10AM S. I need pain med's."	
	O. Pt. NPO for Surgery this pm. Awake alert.	
	Skin w/d to touch. Purple discoloration noted	
	Under left eye. some Edema to left jaw.	
	A. Alteration in Rom to left jaw	
	P. Mou - Sch. for Surgery this pm 6:00. Melan L	
	10 ²⁰ AM McD. Ellis called Surgery for OK. to give po	
	pain med's. Melan L	
	10 ²⁵ Tylenol #3 po for pain. Melan L	

Nurse's Name _____

	Nurse's Name
8/26/02	Rec'd at UT - Ketones Screening complete. No current med. - Althoff
2/23/04	Transferred to Elmore Corr & medical yacht - Althoff

Natin, Ngovin

14/665

Nurse's Notes

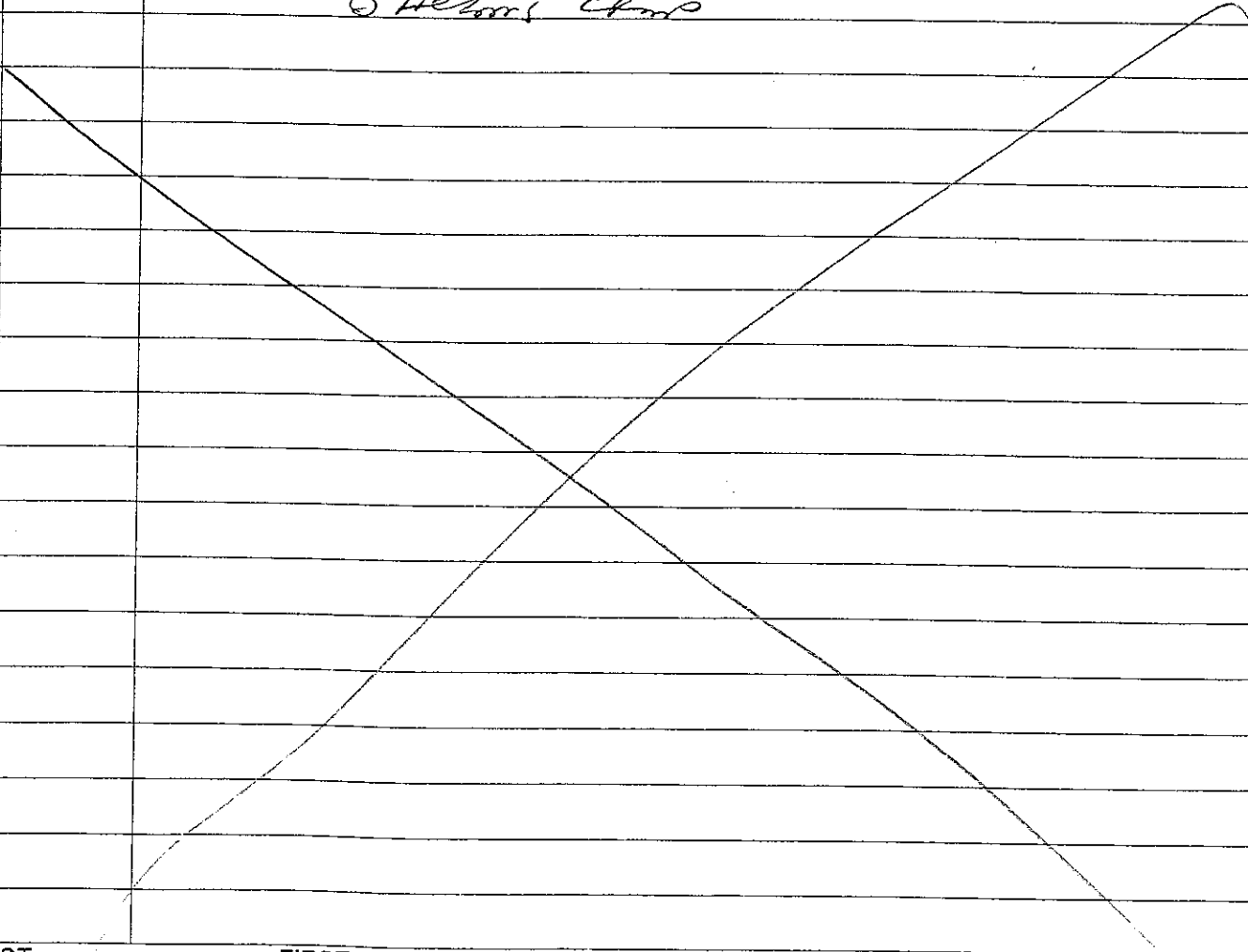
PHYSICIAN PROGRESS NOTES

Patient Name Nation, Marvin I.D. # 141669 Institution LCF

DATE	TIME	NOTES	SIGNATURE
6/13/03		S: Has a hernia in his belly button that seems to be getting larger.	
Wt - 199		Partial Gastrectomy in 1995.	
B/P - 110/80			
P - 78			
R - 18			
		O. WM in NAD. Alert and OX3.	
		neck supple, X SVD	
		Abd SNT - active BS.	
		No rebound or guarding.	
		Incision well-healed vertical from Sternum to umbilicus.	
		3 cm mass at distal end at umbilicus - some difficulty reducing in standing position.	
		A - Ventral Hernia 2° to Surgeon.	
		P - Request consult - Surgeon for evaluation.	
		J. Sp PA - c / Dr. Simon	
		<i>[Signature]</i>	
7/25/03		Neck pain after pulling a mx and had a 125 lb weight put back on his neck. Now has pain x 2 days - Phys Ex: No skin change, or deformity A. Mx strain PL. Robaxin 500 mg TID Motrin 600 mg TID - XR of neck	
		<i>[Signature]</i>	

NAPHCARE

PHYSICIAN'S PROGRESS NOTES

DATE	TIME	NOTES MUST BE SIGNED BY PHYSICIAN
7.9.02	12 ⁰⁰	S: 36yo W ♂ here c/o. Rock on back started ~ 1 wk ago
		D: 968-60-20 133/80
		Several circular red areas of mid back
		A: Ringer Warm
		P: See on back
		B Hesperis Camp
		
NAME- LAST	FIRST	MIDDLE
		AIS #

NC007

PHYSICIAN'S PROGRESS NOTES

CORRECTIONAL MEDICAL SERVICES

INTERDISCIPLINARY PROGRESS NOTES

Patient Name Patison I.D. # _____ Institution _____

DATE	TIME	NOTES	SIGNATURE
Mar 5, 01		<p>patient with sprain to low back; no blunt trauma also chronic pancreatitis - no N/V, no bloody stool o was.</p> <p>abd heard phys cal exam umbilical hernia reducible minimal tenderness to Rels. no guarding; brn; minimal muscle tenderness. Flex 90° able to squat a' RCD SLR 90°</p> <p>SS Low Back pain chronic pancreatitis - stable</p> <p>plan Motn 300 til stool Dysphagia 914 per pan > X100. Persevere Rel as needed</p>	



Complete Both Sides Before Using Another Sheet

Nurse's Name

13/02 Rec'd @ SHC | SCC VO | 1 no med's — BB

7/9/02 See MD on CRNP - Rash on Back
@ 10³⁰ AM 190 wgt, 60, 20, 96⁸, 130/80 — J Myers

7/26/02 TO Limestone Corr. Vol T. send — C. B. M. H.

[The main body of the page is crossed out with a large X.]

Last First Middle Inmate No.
Nation. Marvin 141649



DEPARTMENT OF CORRECTIONS

TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: _____

Date: _____ Time: _____ AM/PM

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS

☐ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: KCIDate: 10/5/04 Time: _____ AM/PM

RELEASE FROM:

☐ Infirmary☐ Segregation☒ Population☐ Mental Health☐ Other _____

RELEASE TO:

☒ DOC☐ Infirmary☐ Mental Health☐ _____

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

PHYSICAL EXAMINATION

Date of last exam: 5/25/04Chest X-Ray Date: _____ Result: OKPPD Reading 6/27/04

Classification: _____

Limitations: _____

LAB RESULTS - - LAST REPORT

	Date	Normal	Abnormal
CBC	_____	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Wears Glasses/Contacts	<input type="checkbox"/>	<input type="checkbox"/>
Dental Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Aide	<input type="checkbox"/>	<input type="checkbox"/>
Other Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>

Receiving Nurse _____

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

MEDICATIONS ☐ Sent w / inmate ☐ Not sent w / inmate
X-RAY FILM ☐ Sent w / inmate ☐ Not sent w / inmate
HEALTH RECORD ☐ Sent w / inmate ☐ Not sent w / inmate
Released to: _____

Date: _____ Time: _____ AM/PM

MEDICATIONS ☐ Received ☐ Not Received
X-RAY FILM ☐ Received ☐ Not Received
HEALTH RECORD ☐ Received ☐ Not Received
CHART REVIEWED ☐ YES ☐ NO

Received by: _____

Signature of Receiving Nurse

Date: _____ Time: _____ AM/PM

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: _____ LAST CLINIC: _____

FOLLOW-UP CARE NEEDED

☐ Medical ☐ Dental☐ Mental Health

	Date	Time	With Whom - - Location (Sending Nurse)	Date/Appt Made w/Whom (Rec Nurse)
<input type="checkbox"/> Medical	_____	_____	_____	_____
<input type="checkbox"/> Dental	_____	_____	_____	_____
<input type="checkbox"/> Mental Health	_____	_____	_____	_____

NURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

	Yes	No
HISTORY		
Drug Use	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Suicide Attempt	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Care	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STATUS		
Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
Appearance	<input type="checkbox"/>	<input type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

	Yes	No
SKIN		
Open Sores	<input type="checkbox"/>	<input type="checkbox"/>
Lice	<input type="checkbox"/>	<input type="checkbox"/>
Edema	<input type="checkbox"/>	<input type="checkbox"/>
Warm & Dry	<input type="checkbox"/>	<input type="checkbox"/>
Cool & Moist	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION		
Alert	<input type="checkbox"/>	<input type="checkbox"/>
Oriented	<input type="checkbox"/>	<input type="checkbox"/>
Uncooperative	<input type="checkbox"/>	<input type="checkbox"/>
Depressed	<input type="checkbox"/>	<input type="checkbox"/>

INTAKE

Sick Call Procedures Explained _____

Height _____

Weight _____

Blood Pressure _____

Temperature _____

Pulse Resp _____

Other _____

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST FIRST MIDDLE)

Nation, Marvin

DOC#

14166

DOB

10/1/66

Race/Sex

W/M

FA

KC

DEPARTMENT OF CORRECTIONS
TRANSFER & RECEIVING SCREENING FORM

RECEIVED: Inmate/Health Record

Institution: ELCDate: 3/6/04 Time: 6:05 AM/PM (PM)

RECEIVED FROM:

Institution/Work Release Center/Free-World Hospital

RECEIVING MEDICAL STATUS

☒ Population☐ Infirmary☐ Isolation

RELEASED: Inmate/Health Record

Institution: LCFDate: 2/23/04 Time: _____ AM/PM

RELEASE FROM:

☐ Infirmary ☐ Segregation☒ Population ☐ Mental Health☐ Other _____

RELEASE TO:

☒ DOC ☐ Infirmary ☐ Mental Health☒ Elmore Cor

Institution/Work Release Center/Free-World Hospital

ALLERGIES:

PHYSICAL EXAMINATION

Date of last exam: 4.13.03Chest X-Ray Date: None Result: _____PPD Reading 4.27.03 6mm

Classification: _____

Limitations: _____

LAB RESULTS - - LAST REPORT

CBC

Urinalysis

RPR HIV

Date

Normal

Abnormal

None4.16.024.16.02☐☒☒☐☐☐Wears Glasses/Contacts ☐Dental Prosthesis ☐Hearing Aide ☐Other Prosthesis ☐

YES

NO

Receiving Nurse

CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL HEALTH PROBLEMS OR COMPLAINTS

PancreatitisMH code -- none

CURRENT MEDICATION - - DOSAGE AND FREQUENCY

None

MEDICATIONS

☐ Sent w / inmate☐ Not sent w / inmate

X-RAY FILM

☐ Sent w / inmate☐ Not sent w / inmate

HEALTH RECORD

☒ Sent w / inmate☐ Not sent w / inmateReleased to: Elmore Cor.

Date: _____ Time: _____ AM/PM

MEDICATIONS

☐ Received☒ Not Received

X-RAY FILM

☐ Received☒ Not Received

HEALTH RECORD

☐ Received☐ Not Received

CHART REVIEWED

☒ YES☐ NO

Received by: _____

Signature of Receiving Nurse

Date: 3-6-04 Time: 6:05 AM/PM (PM)

SCHEDULE FOR CHRONIC CARE CLINIC

DATE: None LAST CLINIC: _____

FOLLOW-UP CARE NEEDED

☐ Medical☐ Dental☐ Mental Health

Date

Time

With Whom - - Location (Sending Nurse)

Date/Appt Made w/Whom (Rec. Nurse)

NURSING ASSESSMENT (SENDING NURSE)
(Noted from health record documentation)

HISTORY		Yes	No
		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Drug Use		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental Illness		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Suicide Attempt		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Chronic Care		<input type="checkbox"/>	<input checked="" type="checkbox"/>

STATUS		Yes	No
		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Special Diet		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Appearance		<input type="checkbox"/>	<input checked="" type="checkbox"/>

OTHER PERTINENT NURSING ASSESSMENT

NURSING ASSESSMENT (RECEIVING NURSE)
(Noted from inmate assessment)

SKIN		Yes	No
		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Open Sores		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lice		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Edema		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Warm & Dry		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cool & Moist		<input type="checkbox"/>	<input checked="" type="checkbox"/>

CONDITION		Yes	No
		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Alert		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oriented		<input checked="" type="checkbox"/>	<input type="checkbox"/>
Uncooperative		<input type="checkbox"/>	<input checked="" type="checkbox"/>
Depressed		<input type="checkbox"/>	<input checked="" type="checkbox"/>

INTAKE

Sick Call Procedures Explained

Height

Weight

Blood Pressure

Temperature

Pulse Resp

Other

6'4"
200
110/76
97.6
80, 4

Signature of Nurse Completing Assessment (Sending Nurse)

Date

Signature of Intake Screening Nurse (Receiving Nurse)

Date

INMATE NAME (LAST FIRST MIDDLE)

DOC#

DOB

Race/Sex

FAC

Nation, Marvin141669[REDACTED]WMLCF

IRASYSTEM TRANSFER FORM

HEALTH STATUS

Transferring Facility: StatonName: Nation Marvin
Number: 141669 Race: B ☒ W ☐ H ☐ Other ☐
Age: _____ Date of Birth: [REDACTED] Sex: ☒ M ☐ FDate: 8/26/02
Time: 1:00 ☒ AM ☐ PMAllergies: NKAFood Handler Approved: ☒ Y ☐ NCurrent Acute Conditions/Problems: [REDACTED]Chronic Conditions/ Problems: [REDACTED]

Current Medications - Name, Dosage, Frequency, Duration:

Acute Short-term Medications: [REDACTED]Chronic Long-term Medications: [REDACTED]Chronic Psychotropic Medications: [REDACTED]Current Treatments: [REDACTED]Follow-up Care Needed: [REDACTED]Last PPD: 4/15/02 Results: [REDACTED] mmsLast Physical: 4/15/02Chronic Clinics: [REDACTED]Specialty Referrals: [REDACTED]Significant Medical History: [REDACTED]Physical Disabilities/Limitations: [REDACTED]Assistive Devices/Prosthetics: [REDACTED]Glasses: [REDACTED]Contacts: [REDACTED]

Mental Health History/Concerns:

Substance Abuse: ☒ Y ☐ NAlcohol: ☒ Y ☐ NDrugs: ☒ Y ☐ NHx Suicide Attempt: Date: 1/1/

Hx Psychotropic Medication

Previous Psychiatric Hospitalizations

Signature and Title: [Signature]Date: 8/26/02

TRANSFER RECEPTION SCREENING

Date: 8/26/02 Time: 2:00 AM ☒ PMS: Current Complaint: noneCurrent Medications/Treatment: noneO: Physical Appearance/Behavior: wellDeformities: Acute/Chronic: noneT P R B/P / A: New man intakeReceiving Facility: LCP

P: Disposition: (Instructions: Check or circle as appropriate)

☒ Routine, Sick Call☐ Instructions Given☐ Emergency Referral☐ HIV/TB Instruction Given☐ Physician Referral:☐ Urgent / Routine☐ Medication Evaluation☐ Work/Program Limitation☐ Special Housing☐ Specialty Referrals☐ Chronic Clinics☐ Mental Health☐ OTHER☐ Infirmary PlacementOther: [REDACTED]

INTRASYSTEM TRANSFER FORM

HEALTH STATUS

Transferring

Facility: KILBY

Date: 6/12/02

Time: 11:00 PM

Allergies: NKA

Food Handler Approved Y/N

Name: Nation, Marvin

AIS: 47669

Age: [REDACTED]

Date of Birth: [REDACTED]

Race: W

Sex: M

Current Acute Conditions/Problems: [REDACTED]

Chronic Conditions/ Problems: [REDACTED]

Current Medications- Name, Dosage, Frequency, Duration:

Acute short term medications [REDACTED]

Chronic Long Term Medications [REDACTED]

Chronic Psychotropic Medications [REDACTED]

Current Treatments: [REDACTED]

Follow up care Needed [REDACTED]

Last PPD 4/15/02 Results [REDACTED]

mms Last Physical 4/15/02

Chronic Clinics [REDACTED]

Specialty Referrals [REDACTED]

Significant Medical History [REDACTED]

Physical Disabilities/Limitations [REDACTED]

Assistive Devices/Prosthetics [REDACTED]

Mental Health History/Concerns [REDACTED]

Glasses [REDACTED]

Contacts [REDACTED]

Substance abuse Y/N [REDACTED]

Alcohol Y/N [REDACTED]

Drugs Y/N [REDACTED]

Hx Suicide Attempt Date [REDACTED]

Hx Psychotropic Medication [REDACTED]

Previous Psychiatric Hospitalizations [REDACTED]

Signature/Title/Date

[REDACTED] 6/12/02

Transfer Reception Screening

Date 6/15/02 Time 6 am pm

S: Current complaint [REDACTED]

Current medications/Treatments [REDACTED]

O Physical Appearance/Behavior

Alert Great cooperative

Deformities: Acute/Chronic [REDACTED]

T 98 P 70 R 20 B/P 120/80 wt 185

P Disposition (Instructions: Check or circle as appropriate)

[REDACTED] Routine sick call Instructions given

[REDACTED] Emergency referral

[REDACTED] HIV/TB Instructions given

[REDACTED] Physician referral

Urgent / Routine

[REDACTED] Medication Evaluation

[REDACTED] Work/Program Limitation

[REDACTED] Special Housing

[REDACTED] Specialty Referrals

[REDACTED] Chronic Clinics

[REDACTED] Mental Health

[REDACTED] OTHER

[REDACTED] Infirmary Placement

Receiving Facility:

[REDACTED]

Signature/ Title:

[REDACTED]

INTRASYSTEM TRANSFER FORM

HEALTH STATUS

Transferring

Facility: KILBY

Date: 6/12/02

Time: 11:00 PM

Allergies: NKA

Food Handler Approved Y/N

Name

AIS

Age

Date of Birth

Race

Sex

Current Acute Conditions/Problems:

Chronic Conditions/ Problems:

Current Medications- Name, Dosage, Frequency, Duration:

Acute short term medications

Chronic Long Term Medications

Chronic Psychotropic Medications

Current Treatments:

Follow up care Needed

Last PPD 4/15/02 Results

mms Last Physical 4/15/02

Chronic Clinics

Specialty Referrals

Significant Medical History

Physical Disabilities/Limitations

Assistive Devices/Prosthetics

Mental Health History/Concerns

Glasses

Contacts

Substance abuse Y/N

Alcohol Y/N

Drugs Y/N

Hx Suicide Attempt Date

Hx Psychotropic Medication

Previous Psychiatric Hospitalizations

Signature/Title/Date

6/12/02

Transfer Reception Screening

Date 6/15/02 Time 6 am pm

S: Current complaint

Current medications/Treatments

O Physical Appearance/Behavior

Deformities: Acute/Chronic

A

P Disposition (Instructions: Check or circle as appropriate)

Routine sick call Instructions given

Emergency referral

HIV/TB Instructions given

Physician referral

Urgent / Routine

Medication Evaluation

Work/Program Limitation

Special Housing

Specialty Referrals

Chronic Clinics

Mental Health

OTHER

Infirmary Placement

Receiving Facility:

Signature/ Title:

MEDICATION ADMINISTRATION RECORD

JTC701

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Tylenol ES 11 PO 7 6-8° PRN 11/12/04 - 2/13/05 Motrin 600mg + PO PRN X 90 days 11/12/04 - 2/13/05	6A PRN EP																														

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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CHARTING FOR		NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE	
Physician	WILLIAMS	THROUGH	1/31/05
Alt. Physician		Telephone No.	
		Alt. Telephone	
Allergies	NKA	Rehabilitative Potential	
Diagnosis			
Medicaid Number	Medicare Number	Complete Entries Checked	
PATIENT	NATION, MARVIN	By:	
		Title:	
PATIENT CODE	ROOM NO	BED	FACILITY
			EM

;TDT01

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE									
CHARTING FOR 12-1-04		THROUGH 12-31-04							
Physician William				Telephone No.				Medical Record No.	
Alt. Physician				Alt. Telephone					
Allergies HKA				Rehabilitative Potential					
Diagnosis									
Medicaid Number		Medicare Number		Complete Entries Checked:					
				By: C. Sullivan		Title:		Date: 11/24/04	
PATIENT Nation, Marvin				PATIENT CODE 141669		ROOM NO.		BED FACILITY CCU	

STD003

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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J. Lekevil 10mg:
p.o. BID x 3 days
11/4/04 - 11/7/04

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	52
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[illegible]

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
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NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

Diagnosis

Medicaid Number	Medicare Number	Complete Entries Checked:
-----------------	-----------------	---------------------------

By: B. Keenell Title: 1st Date: 11/14/0

PATIENT NAME	PATIENT CODE	ROOM NO	BED	FACILITY CODE
Nation Marvin	141669			Elmo

11. Admission

MEDICATION ADMINISTRATION RECORD

STD01

272

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Ensure T po tid c meals	0300 0900 1500 2100	AB	NS	X																											
9/26/04 -																															
Vicodin 5/500mg T po q 4 th prn pain x15d	P R N																														
9/26/04 - 10/10/04																															
Amoxicillin 500mg T po tid x 1 ut	0300 0900 1500 2100	AB	NS	X																											
9/26/04 - 10/03/04																															
Hydrocodone Elixir 10mg po q 4 th prn x 30d	P R N																														
9/27/04 - 10/27/04																															
Saline mouth rinses prn																															
10/2/04 to 10/21/04																															
Motrin 600mg TID x 14 days PRN give c Percogesic 10/7/04 to 10/21/04	6A 12N 6P																														
Percogesic TID x 14 days PRN - give c motrin	6A 12N 6P																														
10/7/04 - 10-21-04																															
Amoxicillin 500mg TID x 4 days HAS CARD	6A 12N 6P																														
10/26/04 to 10/31/04																															
May create all Meds																															
9/26/04																															

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
NURSE'S ORDERS MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																														
CHARTING FOR 10/01/04 THROUGH 10/31/04																														
Physician Robbins															Telephone No.										Medical Record No 141669					
Alt Physician															Alt Telephone															
Allergies NILDA															Rehabilitative Potential															
Diagnosis																														
Medicaid Number										Medicare Number										Complete Entries Checked:										
PATIENT Nation Marvin										By: D. Nguyen										Title: RN										
Date: 10/01										PATIENT CODE 141669										ROOM NO										
BED										FACILITY KCF																				

MEDICATION ADMINISTRATION RECORD

STD01

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
Amoxil 500mg $\dot{\div}$ P.O. TID x 7 days 9/22/04	6A 12N 6P																					X	X	X	X	X	X	X	X	X	X
Tylenol #3 $\dot{\div}$ P.O. 9/22/04 6 ⁰⁰ PM x 7 days	6A 12N 6P																														
Pericocet $\dot{\div}$ P.O. 9/22/04 6 ⁰⁰ PM x 7 days - give 2 Tylenol 650 - See Below	6A 12N 6P																														
Tylenol 650 P.O. 9/22/04 6 ⁰⁰ PM Pain x 7 days give 2 above pericocet	6A 12N 6P																														
Give Tylenol #3 9/22/04 6 ⁰⁰ PM PRN breakthrough pain With above																															
Vicodin $\dot{\div}$ P.O. 9/22/04 6 ⁰⁰ PM x 7 days	6A 12N 6P																														
Motrin 600mg TID x 14 days 9/22/04 \rightarrow 10/2/04	6A 12N 6P																														
Lortab 5mg $\dot{\div}$ P.O. 9/22/04 6 ⁰⁰ PM x 10 days 9/22/04 \rightarrow 10/3/04	6A 12N 6P																														

MEDICATIONS

HOUR

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR

THROUGH

Physician

Alt. Physician

Allergies

Telephone No.

Alt. Telephone

Rehabilitative Potential

Medical Record No

Diagnosis

Medicaid Number

Medicare Number

Complete Entries Checked:

By:

Title:

Date:

PATIENT

PATIENT CODE

ROOM NO

BED

FACILITY

Nation, Marvin

141669

Eln

MEDICATION ADMINISTRATION RECORD

STD01

[illegible]

MEDICATIONS		HOUR		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29			
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																			
CHARTING FOR		4-1-04		THROUGH		4-30-04																													
Physician		Dr. Sommes																		Telephone No.								Medical Record No							
Alt. Physician		D. McArthur, PA																		Alt. Telephone								141669							
Allergies		NKDA																		Rehabilitative Potential															
Diagnosis																																			
Medicaid Number								Medicare Number								Complete Entries Checked:																			
																By: T. Hampton																			
PATIENT								Title: L2N																PATIENT CODE				ROOM NO				BED		FACILITY	
Nashon, Marvin																								141669										1416	

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE												
ARTING FOR		THROUGH										
Physician	Dr. Sanner										Telephone No	
Physician	D. McArthur, PA										Alt. Telephone	
NKDA										Rehabilitative Potential		
gnosis												
Medicaid Number	Medicare Number		Complete Entries Checked:									
				By: T. Hampton								
PATIENT			Title: LPN						Date:			
Nashon, Marvin			PATIENT CODE			ROOM NO		BED		FACILITY COD		
			141669							141669		

INDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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3/30/04 - 4/3/04

[illegible][illegible][illegible]

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	3
STARTING FOR		NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																															
THROUGH																																	

ARTING FOR		THROUGH	
Physician	Dr. Sommes	Telephone No.	Medical Record No.
Physician	D. McArthur, PA	Alt. Telephone	141669
NKDA		Rehabilitative Potential	

gnosis	
Medical Number	Medicare Number
Complete Entries Checked:	
By: T. Hampton	Title: LPN
Date:	

NAME NASTION, MARVIN	PATIENT CODE 1416109	ROOM NO.	BED	FACILITY CODE 1416109
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[illegible]

HARTING FOR 12/01/03		THROUGH 12/31/04	
Physician	Simon		Telephone Number
Att. Physician			Alt. Telephone
Allergies	MKA		Inmate No. 141609
Diagnosis			Rehabilitative Potential

edicaid Number	Medicare Number	Complete Entries Checked				
		By: <i>[Signature]</i>	Title: <i>ZN</i>	Date: <i>11/29/83</i>		
PATIENT <i>Notion Mason</i>			PATIENT CODE <i>141669</i>	ROOM NO	BED	FACILITY CODE

EXHIBIT
A-2

[illegible]

MEDICATIONS		HOUR		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																	
CHARTING FOR Nov '03																THROUGH																	
Physician Samon																Telephone No.										Medical Record No.							
Alt Physician																Alt. Telephone																	
Allergies 0																Rehabilitative Potential																	
Diagnosis Cold / Bronchitis Temp Pulse																																	
Medicaid Number								Medicare Number								Complete Entries Checked:																	
																By: [Signature]																	
PATIENT																Title:								ROOM NO				BED		FACILITY			
Dation Marion																PATIENT CODE								141669						LCP			

[illegible]

CHARTING FOR 08/01/03		THROUGH 08/31/83		Telephone Number		Inmate No.	
Physician Simon				Alt. Telephone		141660	
Alt. Physician				Rehabilitative Potential			
Allergies NKA							
Diagnosis							
Medicaid Number		Medicare Number		Complete Entries Checked		Date: 07/31/03	
				By: L Haney		Title: RN	
PATIENT Nation Markers				PATIENT CODE 141669		ROOM NO.	
						FACILITY LCF	

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

HARTING FOR 7-1-03		THROUGH 7-31-03	
Physician	Simon	Telephone Number	Inmate No.
Alt. Physician		Alt. Telephone	
Allergies		Rehabilitative Potential	
Diagnosis		NKD	

Medical Number	Medicare Number	Complete Entries Checked	Date: 7/3/03	
By: <i>Edna</i>		Title:	PATIENT CODE	ROOM NO.
PATIENT <i>Nation, Marnen</i>			<i>1411209</i>	BED / FACILITY CODE <i>CCF</i>

[illegible]

141669

PATIENT CODE
141669

ROOM NO

Date: 3/16/11

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 11-13-02		THROUGH 11-30-02	
Physician		Telephone Number	Inmate No
Alt. Physician Mr. Camp		Alt. Telephone	
Allergies		Rehabilitative Potential	
Diagnosis			
Medicaid Number	Medicare Number	Complete Entries Checked	Date: 11-13-02
By: [Signature]		Title:	
PATIENT	PATIENT CODE	ROOM NO	FACILITY C
Dorian Martin	141669		LC

[illegible]

STARTING FOR 8-1-02 THROUGH 8-31-02		Telephone Number		Inmate No. 141669
Physician	Fmy 6v	Alt. Telephone		
Physician		Rehabilitative Potential		
Diagnosis	NKA			

Medicaid Number	Medicare Number	Complete Entries Checked	Date: 7-25-04			
By: J. Duran		Title: RN				
PATIENT	PATIENT CODE	ROOM NO	BED	FACILITY CODE		
Walter Mann				SCC		



2006 Page 7 of 59

MEDICATIONS		HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
<p>7 cr (1) Powder (1)</p> <p>TID x 39 days</p> <p>7/9 - 8/9/02</p> <p>Typical 200mg i qd</p> <p>7/19 - 7/24</p> <p>7/14 - 7/15 for</p>	<p>K</p> <p>G</p> <p>6A</p> <p>6A</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p> <p>6</p> <p>7</p> <p>8</p> <p>9</p> <p>10</p> <p>11</p> <p>12</p> <p>13</p> <p>14</p> <p>15</p> <p>16</p> <p>17</p> <p>18</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p> <p>26</p> <p>27</p> <p>28</p> <p>29</p> <p>30</p>																														
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR 7/1/02

Physician *J. Miller*

Att. Physician *Neelma C. C. C.*

Allergies *U/A*

Telephone Number

Inmate No

Alt. Telephone

141669-S

Rehabilitative Potential

Medicaid Number	Medicare Number	Complete Entries Checked	By: <i>Ann Long</i>		Title: <i>LPN</i>	Date: <i>7/9/0</i>
PATIENT <i>Nation, Marcus</i>			PATIENT CODE <i>141669</i>	ROOM NO	BED	FACILITY C

[illegible]

NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE

STARTING FOR <u>Dr. Anderson</u> THROUGH		Telephone Number	Inmate No. <u>141669</u>
Physician		Alt. Telephone	
Surgeon		Rehabilitative Potential	

Medicaid Number	Medicare Number	Complete Entries Checked	Title:				Date:			
PATIENT		By:	PATIENT CODE	ROOM NO.	BED	FACILITY CODE				
Nations Marina										

MEDICATION ADMINISTRATION RECORD

Facility: Kilby

CC#: _____

MONTH March '01

DRUG - DOSE MODE - INTERVAL		INT	HR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Motrin 800 mg TID ± food prn back pain x 10 days 3/5/01	PR	PR	PR																																
Tylenol 650 mg + QID prn moderate pain x 10 days 3/5/01	PR	PR	PR																																
Resource + BID 3/5/01																																			

ALLERGIES: <u>NKDA</u>	DOB/INMATE #: <u>[REDACTED]</u>	LOCATION: <u>N-47</u>	NAME: <u>Nathan, Marvin</u>
CORRECTIONAL MEDICAL SERVICES			

MEDICATION ADMINISTRATION RECORD

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
447111 PANCRELIPASE TAB 09/06/98 TAKE 2 TABLETS 30 MINUTES BEFORE EACH MEAL FOR 30 DAYS Stop: 10/06/98 <i>Rebutter</i>																														
PANCRELIPASE TAB 09/06/98 10/06/98																														
Motrin 600mg BID X 7 days 10/5/98	0900 1800 2100																													

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29										
NURSE'S ORDERS, MEDICATION NOTES, AND INSTRUCTIONS ON REVERSE SIDE																																								
CHARTING FOR	10/01/98	THROUGH	10/31/98																																					
Physician																Telephone No.										Medical Record No.														
Alt. Physician																Alt. Telephone										141996														
Allergies	NKA															Rehabilitative Potential																								
Diagnosis																																								
Medicaid Number	Medicare Number					Complete Entries Checked:										Title:										Date: 9-25														
PATIENT						By: <i>Van Eue no 10</i>										PATIENT CODE										ROOM NO					BED					FACILITY				
NATIONAL MADUTM															141699																									

MEDICATION ADMINISTRATION RECORD

Instructed to report to pic, call 3rd 9th 4th 5-OK 9-24-98 - SV

MEDICATIONS	HOUR	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30		
Tagamet 300mg IV 9 th 12 th x 5 days 9/3/98 9/8/98	0900 2100																																
Demerol 25mg IM 4-6-8 th pm x 5 days 9/3/98 9/8/98																																	
Demerol 50mg IM x1 Dose P R N																																	
D5 NS at 150cc/hr																																	
Demerol 25mg IM q6-8 th pm x 5 days 9-3-98 to 9-8-98	P R N																																
Tagamet 300mg IV 9 th 12 th x 5 days 9-3-98 to 9-8-98	0900 2100																																
Pancrease $\ddot{=}$ PO 30 min Before each meal x 30d	0900 1800 2100																																
Pancrease $\ddot{=}$ PO 30 min before each meal x 30d 9-9-98 10-9-98	0300 0900 1800																																
PANCREASE $\ddot{=}$ PO 30 min before each meal x 30d 9-23-98 10-23-98	0300 0900 1800																																

NURSE'S ORDERS MEDICATION NOTES AND INSTRUCTIONS ON REVERSE SIDE

CHARTING FOR	11/1/98	THROUGH	11/30/98
Physician	Telephone No.		Medical Record No.
Alt. Physician	Alt. Telephone		
Allergies	Rehabilitative Potential		

Diagnosis	Rec'd 9-9-98 SV		
Medicaid Number	Medicare Number	Complete Entries Checked:	
PATIENT	By:	Title:	Date:
141669	141669	ROOM NO	BED FACILITY

II of II

[illegible]



PROGRESS NOTES

Date/Time

Inmate's Name:

NATION, MARVIN #141669 D.O.B.: [REDACTED]

01/12/05 - Problem: S/P facial fractures
S. good occlusion - no facial
pain, no nasal congestion
D. good function (2) (2) malar
bones, bridge occlusion, (2) post
septal unchanged
P. pt cleared from care - RTO prn
[Signature]

2 Jan tu up
1-12-05

UNIVERSITY MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print
Please send this form with # Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Staton 843

Site Phone #

(334) 567 - 1548

Site Fax #

(334) 567 - 1538

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Patient Name: (Last, First)

Nation, Mawin

Alias: (Last, First)

Initiate #

141669

SS Number

[REDACTED]

Date: (mm/dd/yy)

10.20.04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

08.14.85

Potential Release Date: (mm/dd/yy)

11.26.13

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare and Medicaid)

CLINICAL DATA

Requesting Provider:

☐ Physician☒ NP, PA☐ Dental

[Signature]

Facility Medical Director Signature and Date:

[Signature]

☐ Service meets criteria for "approval via protocol"Place a check mark (✓) in the Service Type requested (one only)
and complete additional applicable fields.☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Daycase (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

10.25.04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation Therapy☐ Chemotherapy

Number of Visits/Treatments: 3

☐ Other

Specialist referred to:

ENT - Dr. Borg

Type of Consultation, Treatment, Procedure or Surgery:

Tx for dislocation of nasal bone
Evaluation of (L) Maxillary SinusYou must include copies of pertinent reports such as lab results,
x-ray interpretations and specialty consult reports with this form.☐ Pertinent Documents have been attached and faxed.

History of Illness/Injury/symptoms with Date of Onset:

MVA

[Signature]

H/A's 20 nasal fx

Results of a complaint directed physical examination:

Tnd over (L) maxillary sinus
Minimal edema
H/A's

Previous treatment and response (including medications):

***For security and safety, please do not inform patient of
possible follow-up appointments***

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.☒ Office Service Recommended and Authorized

Date resubmitted:

10.25.04

Regional Medical Director Signature,
printed name and date required:

Will Mosler, MD

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

ET/UV

Mod Class:

99211

UR Auth #:

14336822

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM
Form must be Complete and Legible. You must Type or Print
Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First) Nation, Marvin	Date: (mm/dd/yy) 10.12.09
Site Phone # (334) 567 - 1548	Alias: (Last, First)	Date of Birth: (mm/dd/yy)
Site Fax # (334) 567 - 1538	Inmate # 141669	PHS Custody Date: (mm/dd/yy) 08.14.85
Will there be a charge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	SS Number	Potential Release Date: (mm/dd/yy) 11.26.13
Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		
Responsible party: <input checked="" type="checkbox"/> PHS <input type="checkbox"/> Auto Ins.	<input type="checkbox"/> Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans) <input type="checkbox"/> Other, be specific (Excludes Medicare and Medicaid)	

CLINICAL DATA

Requesting Provider: Dr. Passer CRP	History of illness/injury/symptoms with Date of Onset: MVA SP fracture Chest Pain HIA's 20 days +
<input type="checkbox"/> Service meets criteria for "approval via protocol"	Results of a complaint directed physical examination:
Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields. <input checked="" type="checkbox"/> Office Visit (OV) <input type="checkbox"/> X-ray (XR) <input type="checkbox"/> Scheduled Admission (SA) <input type="checkbox"/> Outpatient Surgery (OS) <input type="checkbox"/> Day/In (DA) <input checked="" type="checkbox"/> Routine <input type="checkbox"/> Urgent	Previous treatment and response (including medications): HIA - oral Surgery
Estimated Date of Service (mm/dd/yy) 11.20.09 (This starts the approval window for the "open authorization period")	
Multiple Visits/Treatments: <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Chemotherapy Number of Visits/Treatments: <input type="checkbox"/> Other	
Specialist referred to: Hean	
Type of Consultation, Treatment, Procedure or Surgery: HIA - month	
You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form. <input type="checkbox"/> Pertinent Documents have been attached and filed.	For security and safety, please do not inform patient of possible follow-up appointments
UM DETERMINATION: <input type="checkbox"/> Alternative Treatment Plan (explain here): <input type="checkbox"/> More Information Requested: (See Attached) <input type="checkbox"/> Resubmitted with requested information.	<input checked="" type="checkbox"/> Outsite Service Recommended and Authorized Date resubmitted:
Regional Medical Director Signature, printed name and date required: Will Mosier, MD	Do not write below this line. For Case Manager and Corporate Data Entry ONLY. Med Class: 99211 UR Auth #: 14336708

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Op Oral Surgery Referral	Effective Dates:	10/11/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Kilby Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14278445	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

**The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

REGIONAL OFFICE
AUSTIN

2000

FILE

[illegible]

PROBATION DEPARTMENT

☐ Section must be collected for "approval" by personnel

 **Related Documents have been attached and filed.**

Abstracts: Treatment and response including medication

For security and safety, please do not return phone or
provide follow-up appointments

UN DETERMINATION

Alternative Dispute Resolution Center

☐ **Case Information Requested:** Case # 17-1403

■ **Modelocked with integrated software 120.**

Regional Medical Director Signature:
 Printed Name: _____

WILL MOSIER, MD

Do not write back this card. For Cash Manager and Corporate Cash Entry Only.

Out Type

0A/0v

THE GARDEN

99211



15278445

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

[Signature]

DEMOGRAPHICS

Site Name & Number: Staton 843	Patient Name: (Last, First) Nation, Mawin	Date: (mm/dd/yy) 10, 20, 04
Site Phone # (334) 567 - 1548	Alias: (Last, First)	Date of Birth: (mm/dd/yy) [REDACTED]
Site Fax # (334) 567 - 1538	Inmate # 141669	PHS Custody Date: (mm/dd/yy) 08, 14, 85
Will there be a charge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Potential Release Date: (mm/dd/yy) 11, 26, 13

Responsible party: ☒ PHS ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans)
☐ Auto Ins. ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☐ Physician ☒ NP, PA ☐ Dental
 [Signature]

Facility Medical Director Signature and Date:

☐ Service meets criteria for 'approval via protocol'

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) _____

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy
 Number of Visits/Treatments: 3 ☐ Chemotherapy
☐ Other:

Specialist referred to: ENT - Dr. Borg

Type of Consultation, Treatment, Procedure or Surgery:

Tx for dislocation of nasal bone
 Evaluation of (L) Maxillary Sinus

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

MVA
 SIP ORIF (L)
 HIA'S 20 nasal fx

Results of a complaint directed physical examination:

Ind over (L) maxillary sinus
 minimal edema
 HIA'S

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

- ☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information

☐ Offsite Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature,
 printed name and date required:

FAXED
 10/2/04
 [Signature]

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

DEMOGRAPHICS

Site Name & Number: Station 843	Patient Name: (Last, First) Nation, Marwin	Date: (mm/dd/yy) 10/20/04
Site Phone # (334) 567 - 1548	Alias: (Last, First)	Date of Birth: (mm/dd/yy) [REDACTED]
Site Fax # (334) 567 - 1538	Inmate # 141669	PHS Custody Date: (mm/dd/yy) 08/14/85
Will there be a charge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Potential Release Date: (mm/dd/yy) 11/26/13

Responsible party: ☒ PHS ☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans)
☐ Auto Ins. ☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider: ☐ Physician ☒ NP, PA ☐ Dental
 [Signature: Offense CRDP]

Facility Medical Director Signature and Date:

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV) ☐ X-ray (XR) ☐ Scheduled Admission (SA)
☐ Outpatient Surgery (OS) ☐ Dialysis (DA)

☒ Routine ☐ Urgent

Estimated Date of Service (mm/dd/yy) 11/20/04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments: ☐ Radiation therapy
 Number of Visits/Treatments: ☐ Chemotherapy
☐ Other:

Specialist referred to: [Signature]

Type of Consultation, Treatment, Procedure or Surgery:

Flu ÷ month

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed

History of illness/injury/symptoms with Date of Onset:

MVA
 S/P facial fracture ORIF (L)
 Arch Bars removed
 HIA's 20 nasal fx

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

Flu ÷ oral Sayer

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):
☐ More Information Requested: (See Attached)
☐ Resubmitted with requested information

☐ Offsite Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

FAXED
 10/21/04
 [Signature]

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Op Oral Surgery Referral	Effective Dates:	10/11/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Kilby Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14278445	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary or Attached Report

3 1/2 cbs. Sp. ORIF @ inc/2 weeks post op.

Arch bones removed today. Hitting prematurely on canines - malocclusion in front
2002. Also c/o nasal bones being changed - no pain. Some "pressure HA's"

① See prison dentist for evaluation of occlusion. Recommend bite equilibration -
relief of canines on @ (orthodontistry if possible).

② See ENT for evaluation of nasal bones, and @ maxillary sinus.

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

③ 40 months
④ 18 months
Signature of Consulting Physician: *[Signature]*

10/20/04
Date Time

Reviewed and Signed By
Medical Director: ⑤ Soft diet x 4-6 weeks

Date Time

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Stafu

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Op Oral Surgery Referral	Effective Dates:	10/11/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Kilby Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14278445	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
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- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P O. Box 967
Brentwood, TN 37024-0967

**The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

UTILIZATION

MANAGEMENT REFERRAL

VIEW FORM

PHS

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

DEMOGRAPHICS		
Site Name & Number: Kibby #349	Patient Name: (Last, First) Nation, Marian	Date: (mm/dd/yy) 10, 06, 04
Site Phone # 334-215-6706	Alias: (Last, First) /	Date of Birth: (mm/dd/yy) [REDACTED]
Site Fax # 334-215-9126	Intimate # 141669	PHS Custody Date: (mm/dd/yy) 04, 12, 02
Will there be a charge? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	SS Number	Potential Release Date: (mm/dd/yy) 10, 27, 09
Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans -) <input type="checkbox"/> Other, be specific (Excludes Medicare and Medicaid):	
Responsible party: <input checked="" type="checkbox"/> PHS <input type="checkbox"/> Auto Ins.		
CLINICAL DATA		
Requesting Provider: <input checked="" type="checkbox"/> Physician <input type="checkbox"/> NP, PA <input type="checkbox"/> Dental Dr. Kean Facility Medical Director Signature and Date: Mike Robb	History of Illness/Injury/Symptoms with Date of Onset: S/P (L) orif	
<input type="checkbox"/> Service meets criteria for "approval via protocol" Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.	Results of a complaint directed physical examination:	
<input type="checkbox"/> Office Visit (OV) <input type="checkbox"/> X-ray (XR) <input type="checkbox"/> Scheduled Admission (SA) <input type="checkbox"/> Outpatient Surgery (OS) <input type="checkbox"/> Dialysis (DX) <input checked="" type="checkbox"/> Routine <input type="checkbox"/> Urgent	Previous treatment and response (including medications):	
Estimated Date of Service (mm/dd/yy) (This starts the approval window for the "open authorization period")	Multiple Visits/Treatments: <input type="checkbox"/> Radiation Therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other:	
Number of Visits/Treatments:	Specialist referred to: oral surgeon	
Type of Consultation, Treatment, Procedure or Surgery: F/U x 2 wk. - arch bar removal 10/20/04 115 SM / armichael H.	You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form. <input type="checkbox"/> Pertinent Documents have been attached and filed.	
For security and safety, please do not inform patient of possible follow-up appointments		
U/M DETERMINATION:		
<input type="checkbox"/> Alternative Treatment Plan (explain how): <input type="checkbox"/> More Information Requested: (See Attached) <input type="checkbox"/> Resubmitted with requested information.	<input type="checkbox"/> Offsite Service Recommended and Authorized Date resubmitted:	
Regional Medical Director Signature, printed name and date required:		
Do not write below this line. For Case Manager and Corporate Data Entry ONLY.		
Cert Type:	Mod Class:	UR AUTH:

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Op Surgical Followup Referral	Effective Dates:	10/04/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Kilby Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14257495	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility
- HIPAA: Please be advised Prison Health Services, Inc. ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS.
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and returned with an officer to the correctional facility.

Clinical Summary of Attached Request

2 wks S/P ORIF @ the Ps. Satisfactory.

Release from MF. occlusion = some proximity @.

Plan - (1) Return to work for 2nd bcr removal

(2) Administer diet to patient → soft mechanical

(3) NPO P MV night prior to surgery in 72 hrs

(4) Will need dental evaluation later for occlusion.

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician:

Reviewed and Signed By
Medical Director:

Date

Time

Date

Time

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Outpatient Ent Referral	Effective Dates:	09/22/2004
Effective:	Visits authorized for 60 days from effective date	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14218567	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility
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- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P O. Box 967
Brentwood, TN 37024-0967

9/22 @ 300

**The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

***** For security and safety, please do not inform patient of possible follow-up appointments. *****

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

PRISON HEALTH SERVICES: AUTHORIZATION LETTER

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Outpatient Ent Referral	Effective Dates:	09/22/2004
Effective:	Visits authorized for 60 days from effective date.	Visits Authorized:	1
Responsible Facility:	Staton Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14218567	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility.
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- Payment will not be processed until we receive a clinical summary

For Payment Please Submit Claims To:

Prison Health Services
P.O. Box 967
Brentwood, TN 37024-0967

9/22 @ 300

**The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Kilby #840

Site Phone #

334-215-6706

Site Fax #

334-215-9126

Patient Name: (Last, First)

Nation, Marvin

Alias: (Last, First)

Inmate #

141669

SS Number

Date: (mm/dd/yy)

9/29/04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

4/12/02

Potential Release Date: (mm/dd/yy)

10/27/09

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

Dr Kean

Facility Medical Director Signature and Date:

Michael Feltz MD.

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☒ Routine☐ Urgent

Estimated Date of Service (mm/dd/yy)

____/____/____

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: _____

☐ Other: _____

Specialist referred to: Oral Surgeon

Type of Consultation, Treatment, Procedure or Surgery:

Post-op Flu x 1 week

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form

☐ Pertinent Documents have been attached and faxed

History of illness/injury/symptoms with Date of Onset:

SLP @ ORIF

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information

Date resubmitted:

____/____/____

Regional Medical Director Signature, printed name and date required:

UR Auth #:

14257495

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

Auth No: Date of Service 9 / 29 / 04**Provider Consultation Report** (Complete and Return with Inmate)

Inmate: Marvin Nation ID: _____ DOB: [REDACTED]
 Provider: _____ Site ID: _____ Phone: _____
 Provider: _____ Location: _____

Health Services Authorized (See Attached Request Copy)

- For security reasons, inmates must NOT be informed of date, time or location of any proposed treatment or possible hospitalization.
- Due to security considerations all tests and treatments to be scheduled by CMS

Review of Case

5 days sip ORIF (L) zmc. fr, cluster signet fr.
 Afrin nasal spray -

Diagnosis and Prescription Suggestions to be Reviewed by CMS Medical Director:

- ① Diet - suggest ↑ apple sauce, puddings, yogurt - bouillon
- ② Flu ÷ ulc - probable relation of IMF.
- ③ Continue pain meds

Can equivalent medication substitution be used? Y N

Followup needed? (Y) N

If followup needed explain purpose

i ulc flu

i ulc

 Provider  Date 9/29/04 CMS Nurse _____ Date / /

 Recommendation After Review of Consultant's Report: ☐ No Further Action ☐ Implement the Following:
CMS Physician: _____ Date: / /

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Staton 843

Site Phone #

(334) 567 - 1548

Site Fax #

(334) 567 - 1538

Patient Name: (Last, First)

Nation, Marvin

Alias: (Last, First)

Inmate #

141669

SS Number

[REDACTED]

Date: (mm/dd/yy)

09/23/04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

08/14/85

Potential Release Date: (mm/dd/yy)

11/26/13

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☒ Physician☐ NP, PA☐ Dental

WINFRED D. WILLIAMS

Facility Medical Director Signature and Date:

[Signature]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☒ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☒ Urgent

Estimated Date of Service (mm/dd/yy)

___/___/___

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: ___

☐ Other: ___

Specialist referred to:

Dr. Kean

Type of Consultation, Treatment, Procedure or Surgery:

Surgery - ORIF maxillary fracture
Baptist East 9/24/04 2pm

History of illness/injury/symptoms with Date of Onset:

ZMC fracture
maxillary alveolar fracture
Sustained in MVA on 9/21/04

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

Oral Surg. consult on 9/22/04
ENT on 9/22/04FAXED
9/23/04
11:00

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information

Date resubmitted:

___/___/___

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

OSR 37

Form must be Complete and Legible. You must
 Please send this with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Kilby #340

Site Phone #

334-215-6706

Site Fax #

334-215-9126

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Patient Name: (Last, First)

Nation, Marvin

Alias: (Last, First)

141669

Inmate #

SS Number

Date: (mm/dd/yy)

9.29.04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

1/1/04

Potential Release Date: (mm/dd/yy)

1/1/04

Responsible party:

☒ PHS

☐ Auto Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)

☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☒ Physician

☐ NP, PA

☐ Dental

Facility Medical Director Signature and Date:

Mike Robles

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)

☐ X-ray (OR)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☒ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

10.10.04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

☐ Chemotherapy

Number of Visits/Treatments:

☐ Other

Specialist referred to:

Dr. Kean

Type of Consultation, Treatment, Procedure or Surgery:

TWIC S/P O R I F

History of Illness/Injury/Symptoms with Date of Onset:

S/P O R I F

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

Pain med
Soft Diet

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information

☐ Offsite Service Recommended and Authorized

Date resubmitted:

1/1/04

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

Marvin Nation

September 22, 2004

New Patient

Problem:

Facial fracture.

S:

The patient notes he was a passenger in a prison van yesterday which was involved in a motor vehicle accident. He notes he sustained a puncture wound to his leg and struck the left side of his face. The patient notes that subsequent to that he has had significant facial pain on the left-hand side. He has had a change in appearance, specifically that his "cheek is pushed in", and has been unable to open his mouth freely. He notes that his upper teeth are loose and uncomfortable. The patient notes he did have a CT scan performed at Baptist Hospital which he did not bring for his appointment.

O:

The examination today reveals that the patient's extraocular muscle motions are within normal limits. The patient does have a small achymosis subconjunctival on the left-hand side. The patient's pupillary reflexes are symmetrical. Nasal exam reveals that the patient does have a deviated nasal dorsum and septum; however, these are not from his current injury. Nose is deviated to the right with a septal deviation to the left posteriorly. The patient does have depression of the malar eminence on the left-hand side and his free-floating left maxillary arch. No open fracture line is noted. The patient has marked tenderness in the body of the mandible on the left-hand side, once again with no exposed bone. Neck exam is unremarkable. Ear exam is unremarkable.

P:

Is for referral to Dr. Keen this afternoon with an unstable maxillary arch fracture with possible mandible fracture with depressed malar prominence fracture.

Neil Stronach, M.D.

NS/as

CC: Elmore County Correctional Center

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Staton 843

Site Phone #

(334) 567 - 1548

Site Fax #

(334) 567 - 1538

Patient Name: (Last, First)

Nation, Mawin

Alias: (Last, First)

Inmate #

141669

SS Number

[REDACTED]

Date: (mm/dd/yy)

09/22/04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

08/14/85

Potential Release Date: (mm/dd/yy)

11/26/13

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS
☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)
☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☐ Physician☒ NP, PA☐ Dental

[Signature: Assistant CRNP]

Facility Medical Director Signature and Date:

[REDACTED]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☒ Urgent

ASAP

Estimated Date of Service (mm/dd/yy)

9/22/04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments:

☐ Other:

Specialist referred to:

Dr. Kean
ORAL Surgeon

Type of Consultation, Treatment, Procedure or Surgery:

Evaluation of facial
fracture 9/22/04

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed

History of illness/injury/symptoms with Date of Onset:

MOA = hospital evaluation
9/21/04

Results of a complaint directed physical examination:

Facial Fracture
Teeth Loose
No Swelling / lg amt of e demerol

Previous treatment and response (including medications):

FAXED
9/22/04
(FZ)

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.☐ Offsite Service Recommended and Authorized

Date resubmitted:

[REDACTED]

Regional Medical Director Signature,
printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

OSR # 37

09/23/2004 11:33 20552114

HAMILTON

PAGE 20/20

09/23/2004 THU 8:45 FAX 334 3958156

REGIONAL OFFICE
Staten Health Unit

HAMILTON

013

002/002

09/22/2004 18:58 FAX 251 388 1015

DR NIKS WEST

0001 V61/VU6

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please print this form with the Authorization Letter to the service provider at the time of the Approval.

FHS

Station #43 Site Phone # (334) 567 - 1548 Site Fax # (334) 567 - 1538 Not done by a change of Responsible party: <input checked="" type="checkbox"/> Auto top		Demographics Patient Name: <u>Daton, Marvin</u> Address: <u>141669</u> City: <u>9122104</u> State: <u>GA</u> Zip: <u>30114</u> Date of Birth: <u>11/26/1933</u>	
Clinical Data Referring Physician: <u>Dr. Nicks West</u> Referral Type: <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary Referral Date: <u>9/22/04</u> Referral Reason: <u>MOA = hospital evaluation</u> Date of Referral: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u> Referral Type: <u>Facial Fracture</u> Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u> Referral Type: <u>Facial Fracture</u> Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u>		History of Illness/Injury History of Illness/Injury: <u>MOA = hospital evaluation</u> Date of Referral: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u> Referral Type: <u>Facial Fracture</u> Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u>	
Referral Information Referral Type: <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u> Referral Type: <u>Facial Fracture</u> Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u>		Referral Information Referral Type: <input checked="" type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u> Referral Type: <u>Facial Fracture</u> Referral Date: <u>9/22/04</u> Referral Status: <u>ASAP</u> Referral Source: <u>ORAC Surgeon</u>	

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Station 843

Site Phone #

(334) 567 - 1548

Site Fax #

(334) 567 - 1538

Patient Name: (Last, First)

Nation, Marvin

Date: (mm/dd/yy)

09/22/04

Alias: (Last, First)

Date of Birth: (mm/dd/yy)

[REDACTED]

Inmate #

141669

PHS Custody Date: (mm/dd/yy)

08/14/85

Will there be a charge?

☒ Yes ☐ No

Sex

☐ Male ☐ Female

SS Number

[REDACTED]

Potential Release Date: (mm/dd/yy)

11/26/13

Responsible party:

☒ PHS☐ Auto Ins.☐ Health Ins (Excludes Medicare/Medicaid Managed Care alternative plans)☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☐ Physician☒ NP, PA☐ Dental

Kassir CRNP

Facility Medical Director Signature and Date:

[REDACTED]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☒ Urgent

ASAP

Estimated Date of Service (mm/dd/yy)

9/22/04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy☐ Chemotherapy

Number of Visits/Treatments: _____

☐ Other: _____

Specialist referred to:

ENT - Chapman

Type of Consultation, Treatment, Procedure or Surgery:

Evaluation of facial fracture
9/22/04 1:30 pm

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed

History of illness/injury/symptoms with Date of Onset:

MOA = hospital evaluation
9/21/04

Results of a complaint directed physical examination:

Facial fracture Left Side
Teeth loose
moderate/large amt edema

Previous treatment and response (including medications):

FAXED
9-22-04

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Offsite Service Recommended and Authorized☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information

Date resubmitted:

[REDACTED]

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Med Class:

UR Auth #:

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Form must be Complete and Legible. You must Type or Print

Please send this form with the Authorization Letter to the service provider at the time of the Appointment

PHS

DEMOGRAPHICS

Site Name & Number:

Station 843

Site Phone #

(334) 567 - 1548

Site Fax #

(334) 567 - 1538

Patient Name: (Last, First)

Naton, Mawin

Alias: (Last, First)

Inmate #

141669

SS Number

[REDACTED]

Date: (mm/dd/yy)

09/22/04

Date of Birth: (mm/dd/yy)

[REDACTED]

PHS Custody Date: (mm/dd/yy)

08/14/05

Potential Release Date: (mm/dd/yy)

11/26/13

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ Self
☐ Auto Ins.☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans)
☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☐ Physician☒ NP, PA☐ Dental

[Signature: Dr. Kean]

Facility Medical Director Signature and Date:

[Signature]

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☒ Office Visit (OV)☐ X-ray (XR)☐ Scheduled Admission (SA)☐ Outpatient Surgery (OS)☐ Dialysis (DA)☐ Routine☒ Urgent

ASAP

Estimated Date of Service (mm/dd/yy)

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation therapy

Number of Visits/Treatments:

☐ Chemotherapy☐ Other

Specialist referred to:

Dr. Kean
Oral Surgeon

Type of Consultation, Treatment, Procedure or Surgery:

Evaluation of facial
fracture 9/22/04

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of illness/injury/symptoms with Date of Onset:

MVA & hospital evaluation
9/21/04

Results of a complaint directed physical examination:

Facial Fracture
Teeth Loose
No Swelling / lg ant of e dema

Previous treatment and response (including medications):

OSR # 37

Dealt
9-22-04

FAXED

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):☐ More Information Requested: (See Attached)☐ Resubmitted with requested information.☐ Office Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature,
printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Mod Class:

LIC AUTH #:

PHYSICIAN'S ORDERS

MHR 09/04

USE BALL POINT PEN ONLY AND PRESS FIRMLY!

ALLERGIES

Weight



Another brand of generically equivalent product may be dispensed unless checked or initiated

CRT
Order #

PHYSICIAN'S ORDERS

ADDRESSOGRAPH

Orders for Marvin Nation:

- ① CBC
- ② NPO p MW tonight 9/23/04
- ③ Plan to Baptist East hospital tomorrow
2:00 pm for surgery.

Marvin Nation

1

Date Ordered
9/23/04

Time Ordered

Transcribers Initials/Time

Physician Signature

ADDRESSOGRAPH

2

Date Ordered

Time Ordered

Transcribers Initials/Time

Physician Signature

ADDRESSOGRAPH

3

Date Ordered

Time Ordered

Transcribers Initials/Time

Physician Signature

Auth No: _____

Date of Service: _____

Provider Consultation Report (Complete and Return With Inmate)Inmate: NAJWA, MARVINInmate ID: 141669DOB: [REDACTED]Institution: Elmwood

Site ID: _____

Phone: _____

Provider: _____

Location: _____

Health Services Authorized (See Attached Request Copy)

- * For security, inmates must NOT be informed of recommended treatment or possible hospitalization.
- * Due to security considerations all tests and treatments to be scheduled by CMS

Review of Case

38 YOWM involved in MVA yesterday 1330. Stationary vehicle - Manic was
 backseat passenger struck by car going ~60 mph. ? Loc. has obvious
 zygomatic injuries - ① maxillary fracture. CT scan unavailable.
 of diplopia. some pain upon eye movement. some blurred vision on extreme lateral gaze.

Diagnosis and Prescription Suggestions to be Reviewed by CMS Medical Director:

- ① ZMC fx - unknown extent.
- ② maxillary fracture.
- needs repair - stabilization.

Can equivalent medication substitution be used? ☐Follow up needed? ☐

If follow up needed, explain purpose

Plan ORIF of above fractures ASAP. (2-3 days).

① NPO 7 MW night prior to surgery.

② Lorazepam 7.5mg i po q4h prn pain

③ Amoxicillin 500mg i po TID ~~with food~~ x 10 days.

④ Call Dr. Keen 222-3442 for any questions/problems.

Provider: [Signature]Date: 9/22/04 CMS Nurse: - KMED 2 SYSTEM, -

Date: _____

Recommendation After Review of Consultant's Report:

☐ No Further Action☐ Implement the Following

⑤ liquid/puree diet.

CMS Physician: [Signature]Date: 9/22/04

FROM : Dobbs

FAX NO. : 2562302595

Aug. 04 2003 01:44PM P2

Auth #: 030804L0PS05

Appt Date: _____

NaphCare
Hospital/Consultant Referral FormInmate Name: Marvin Nation AIS#: 1411669 Date: 8/1/09DOB: [REDACTED] Race: White Sex: male Allergies: NRDAHistory of working diagnosis (when first recognized, progression of symptoms, physical findings, lab results, current symptoms, current treatments): See copy of Dr. Winham's notesSERVICES REQUESTED/PROVIDER: umbilical hernia repair - dual mesh.Signature (M.D.): [Signature] Dr. Simon

Pertinent Chronic Conditions/Diagnosis: _____

DOC Facility: LCF

Time Out: _____

Receiving Facility/Hospital: _____

Return Time: _____

Route of Transportation: (X) _____ Ambulance _____ DOC Van _____ Other: _____

Date & Result/Last PPD: _____

Date & Result/Last Chest X-Ray: _____

OFFSITE HEALTHCARE REPORT: _____

EOS
3/13/10

This pt was the one I was telling Dr. Mosier about when he was here the 1st time and he said to go on with the surgery. His hernia is very large.

Borne

Date: _____ Time: _____
_____ of patient's discharge

attached) No _____

Date: _____

Date: _____

Woodland
12-1-03
Dr. Winham
NPO PMN

Bill to NaphCare 950 22nd St. N. Suite 825 Birmingham, AL. 35203
Beverly Douglas, R.N. Utilization Review Manager* 205-458-8370 or 1-800-771-0315

change to
#3 per
Dr. Simon
T.E



Surgical Arts, P.C.

1930 Alabama Hwy, 157
Cullman, Alabama 35058
Office: 256/734-7850
After Hours: 256/737-2000

POB Suite 3400
1912 Cherokee Ave.
Cullman, Alabama 35055
Office: 256/734-3737
After Hours: 256/739-3500

Gregory S. Windham, M.D.
William E. Smith, Jr., M.D.
Joan W. Jacobelli, M.D.
J.W. Evans, Jr., M.D.
Jeffery D. Manord, M.D.

July 31, 2003

Dr. Colett Simon
c/o Limestone Correctional Facility
28779 Nick Davis Rd
Capshaw, AL 35742

Re: MARVIN NATION
D.O.B. [REDACTED]

Dear Colett:

Mr. Nation was seen in the office on 7/31/2003, weight 193, BP 128/80. He has a fairly large umbilical hernia which we have recommended be repaired laparoscopically with dual mesh as an outpatient at Woodland Medical Center. We can do that at your discretion. I very much appreciate your continued confidence and support.

Warmest regards,

Gregory S. Windham, MD

Gregory S. Windham, M.D.

GSW/rb

GS
8/3/03

Appl. Date:

NaphCare
Hospital/Consultant Referral Form

Inmate Name: Dation, Marvin AIS#: 1411669 Date: 6/13/03

DOB: [REDACTED] Race: White Sex: Male Allergies: NKDA

History of working diagnosis (when first recognized, progression of symptoms, physical findings, lab results, current symptoms, current treatments):

Partial Gastrectomy in 1995
a 3 cm hernia at distal
end of incision. Slight
difficulty reducing in standing
position.

SERVICES REQUESTED/PROVIDER: Surgical consult &
Dr. Windham

Signature (M.D.):

Pertinent Chronic Conditions/Diagnosis:

DOC Facility: LCF

Time Out:

Receiving Facility/Hospital:

Return Time:

Route of Transportation: (X) Ambulance

DOC Van Other:

Date & Result/Last PPD:

Date & Result/Last Chest X-Ray

OFFSITE HEALTHCARE REPORT:

Orders/Recommendations:

Physician:

Date:

Time:

Notify (Facility):

Advanced Medical Directive: Yes

(Attached) No

of perianthe discharge

Report called to: (Name/Title):

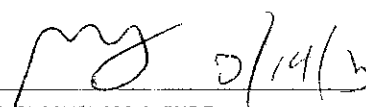
Date:

Signature & Title:

Date:

Bill to NaphCare 950 22nd St., N. Suite 825 Birmingham, AL 35203
Beverly Douglas, R.N. Utilization Review Manager* 205-458-8370 or 1-800-771-0315

EYE EXAMINATION SHEET

TO: (Service Physician) <i>Bradford</i>	FROM: (Requesting Ward Med Fac Phys) <i>LCP</i>	Date of Request: <i>3-14-03</i>
Reason For Request: (Complaints and Finding) <i>Routine eye exam</i>		
Past History		
Old Rx		
Signature	Type of Consult <input type="checkbox"/> Emergency <input type="checkbox"/> Routine	
CONSULTATION REPORT		
Subjective: OD <i>20/13 5</i> OS <i>20/15</i>		OPHTH: <i>30% 90/10NL</i>
New Rx: OD OS		Ext: Date Dispensed & Initials:
Seg Type:	<div style="display: inline-block; transform: rotate(-45deg);"> <i>PLANO</i> / <i>NOI</i> <i>R'd</i> </div>	
IDP & Time:		
Frame: Size: Color:		
 OPTOMETRIST'S SIGNATURE		
Patients Last Name <i>Nation, Marvin</i>	First <i>Marvin</i>	Middle <i></i>
Age <i>36</i>	R/S <i>W</i>	ID No <i>141669</i>

Specimen #	Type	Primary Lab	Report Status	Pg
267-684-8007-0	R	YX	Final	1
Time 0730 ECC/STAT FAX TO 334 567-1538 CD- 41147603537				
Patient Name		Sex	Age (Yr/Mo)	
NATION, MARVIN		M	038/06/04	
Pat Addr				
Date Collected	Date Entered	Date Reported		
09/23/04	09/23/04	09/23/04	3579	

LabCorp

Clinical Information	
DOB: [REDACTED]	Fasting: Y
Physician ID	Patient ID
WILLIAMS	141669
Account	
Staton Correctional Facility 01308900	
Prison Health Services	
2690 Marion Spillway Road	
Elmore, AL 36205-0000	
334-567-1548	

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
White Blood Cell (WBC) Count	8.2		x10E3/uL	4.0 - 10.5	YX
Red Blood Cell (RBC) Count	4.91		x10E6/uL	4.10 - 5.60	YX
Hemoglobin	14.3		g/dL	12.5 - 17.0	YX
Hematocrit	41.4		%	36.0 - 50.0	YX
MCV	84		fL	80 - 98	YX
MCH	29.1		pg	27.0 - 34.0	YX
MCHC	34.6		g/dL	32.0 - 36.0	YX
RDW	13.6		%	11.7 - 15.0	YX
Platelets	194		x10E3/uL	140 - 415	YX
Neutrophils	58		%	40 - 74	YX
Lymphs	31		%	14 - 46	YX
Monocytes	8		%	4 - 13	YX
Eos	2		%	0 - 7	YX
Basos	1		%	0 - 3	YX
Neutrophils (Absolute)	4.8		x10E3/uL	1.8 - 7.8	YX
Lymphs (Absolute)	2.5		x10E3/uL	0.7 - 4.5	YX
Monocytes (Absolute)	0.7		x10E3/uL	0.1 - 1.0	YX
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	YX
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	YX

Lab: YX LabCorp Montgomery Hull Director: Alton Sturtevant, PhD
 543 Hull Street Montgomery, AL 36104-0000

For inquiries, the physician may contact: Branch: 800-659-3324 Lab: 334-263-5745
 Last Page of Report

10/27/04
 (W)

Patient Name:	Nation, Marvin	Inmate Number:	141669NA
Service Authorized:	Office Visits: Op Surgical Followup Referral	Effective Dates:	10/04/2004
Effective:	Visits authorized for 60 days from effective date	Visits Authorized:	1
Responsible Facility:	Kilby Correctional Facility	Contact Name:	Michelle Pope
Authorization Number:	14257495	Telephone Number:	(334)395-5973 Ext 14

Note to Provider of Services:

- Medicare/Medicaid do not cover any health services provided to an inmate in custody, except in certain circumstances not applicable to this inmate.
- Authorization is diagnosis and procedure specific. Any additional tests, procedures, and inpatient or outpatient services must receive prior authorization to ensure benefit eligibility and payment. (Use above contact name and telephone number)
- Authorization for payment of service is guaranteed only if service is provided during the actual time of confinement to the referring correctional facility
- HIPAA: Please be advised Prison Health Services, Inc ("PHS") is not a covered entity under HIPAA's Rule on the Privacy of Individually Identifiable Health Information Standard ("Privacy Rule"). Because PHS does not engage in electronic transactions under HIPAA's Electronic Transactions and Code Set Standards ("Transaction Standards"), HIPAA's Privacy Rule does not apply to PHS
- Payment will not be processed until we receive a clinical summary.

For Payment Please Submit Claims To:

Prison Health Services
P O Box 967
Brentwood, IN 37024-0967

**The consulting physician should complete this section.
The completed form will be sealed in the attached envelope and
returned with an officer to the correctional facility.**

Clinical Summary or Attached Report

2 wks S/P ORIF @ the Ro. Satisfactory.

Recheck from MF. occlusion = some protrusion @.

Plan - (1) Return to the Ro for removal

(2) Advise dent to pull → soft unchained

(3) NPO p the night prior to surgery in the Ro

(4) will need dental evaluation later for occlusion.

*** For security and safety, please do not inform patient of possible follow-up appointments. ***

Signature of Consulting Physician:

Date

Time

Reviewed and Signed By
Medical Director:

Date

Time

must be Complete and Legible. You must Type in the Authorization Letter to the service provider at the time of the Appointment
Please send this form.

PHS

DEMOGRAPHICS

Site Name & Number:

Katby #840

Site Phone #

334-215-6706

Site Fax #

334-215-9126

Patient Name: (Last, First)

Nation, Marwan

Date: (mm/dd/yy)

10, 06, 04

Alias: (Last, First)

1

Date of Birth: (mm/dd/yy)

[REDACTED]

Inmate #

141669

PHS Custody Date: (mm/dd/yy)

04, 12, 02

SS Number

[REDACTED]

Potential Release Date: (mm/dd/yy)

10, 27, 09

Will there be a charge?

☒ Yes ☐ No

Sex

☒ Male ☐ Female

Responsible party:

☒ PHS

☐ Auto Ins.

☐ Health Ins. (Excludes Medicare/Medicaid Managed Care alternative plans.)

☐ Other, be specific (Excludes Medicare and Medicaid):

CLINICAL DATA

Requesting Provider:

☒ Physician

☐ NP, PA

☐ Dental

Dr. Klean

Facility Medical Director Signature and Date:

Mike Pohl

☐ Service meets criteria for "approval via protocol"

Place a check mark (✓) in the Service Type requested (one only) and complete additional applicable fields.

☐ Office Visit (OV)

☐ X-ray (XR)

☐ Scheduled Admission (SA)

☐ Outpatient Surgery (OS)

☐ Dialysis (DA)

☒ Routine

☐ Urgent

Estimated Date of Service (mm/dd/yy)

10, 06, 04

(This starts the approval window for the "open authorization period")

Multiple Visits/Treatments:

☐ Radiation Therapy

Number of Visits/Treatments:

☐ Chemotherapy

☐ Other:

Specialist referred to:

oral surgeon

Type of Consultation, Treatment, Procedure or Surgery:

F/U x 2 wks - Arch
bar removal

You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form.

☐ Pertinent Documents have been attached and faxed.

History of Illness/injury/symptoms with Date of Onset:

S/P (L) arif

Results of a complaint directed physical examination:

Previous treatment and response (including medications):

For security and safety, please do not inform patient of possible follow-up appointments

UM DETERMINATION:

☐ Alternative Treatment Plan (explain here):

☐ More Information Requested: (See Attached)

☐ Resubmitted with requested information.

☐ Offsite Service Recommended and Authorized

Date resubmitted:

Regional Medical Director Signature, printed name and date required:

Do not write below this line. For Case Manager and Corporate Data Entry ONLY.

Cert Type:

Mod Class:

UR Auth #:



Laboratory Corporation of America

SPECIMEN	TYPE	PRIMARY LAB	REPORT STATUS
267-684-8007-0	S	YX	COMPLETE

Page #: 1

ADDITIONAL INFORMATION

ECC/STAT
FAX TO 334 567-1538

FASTING: Y
DOB: [REDACTED]

CLINICAL INFORMATION

CD- 41147603537

PATIENT NAME

SEX

AGE(YR / MOS)

PHYSICIAN ID

PATIENT ID

NATION, MARVIN

M

38 / 6

WILLIAMS W

141669

PT. ADD:

ACCOUNT: STATION CORRECTIONAL FACILITY

PRISON HEALTH SERVICES

2690 Marion Spillway Road

Elmore

AL

36205-0000

DATE OF SPECIMEN	TIME	DATE RECEIVED	DATE REPORTED	TIME
9/23/2004	7:30	9/23/2004	9/23/2004	16:40 3579

ACCOUNT NUMBER: 01308900

TEST	RESULT	LIMITS	LAB
CBC With Differential/Platelet			
White Blood Cell (WBC) Count	8.2 x10E3/uL	4.0 - 10.5	YX
Red Blood Cell (RBC) Count	4.91 x10E6/uL	4.10 - 5.60	YX
Hemoglobin	14.3 g/dL	12.5 - 17.0	YX
Hematocrit	41.4 %	36.0 - 50.0	YX
MCV	84 fL	80 - 98	YX
MCH	29.1 pg	27.0 - 34.0	YX
MCHC	34.6 g/dL	32.0 - 36.0	YX
RDW	13.6 %	11.7 - 15.0	YX
Platelets	194 x10E3/uL	140 - 415	YX
Neutrophils	58 %	40 - 74	YX
Lymphs	31 %	14 - 46	YX
Monocytes	8 %	4 - 13	YX
Eos	2 %	0 - 7	YX
Basos	1 %	0 - 3	YX
Neutrophils (Absolute)	4.8 x10E3/uL	1.8 - 7.8	YX
Lymphs (Absolute)	2.5 x10E3/uL	0.7 - 4.5	YX
Monocytes (Absolute)	0.7 x10E3/uL	0.1 - 1.0	YX
Eos (Absolute)	0.2 x10E3/uL	0.0 - 0.4	YX
Baso (Absolute)	0.1 x10E3/uL	0.0 - 0.2	YX

LAB: YX LabCorp Montgomery Hull
543 Hull Street, Montgomery, AL 36104-0000

DIRECTOR: Alton Sturtevant B PhD

9/24/04
(v)

Results are Flagged in Accordance with Age Dependent Reference Ranges

Last Page of Report

Specimen #	Type	Primary Lab	Report Status	Pg
267-684-8007-0	R	YX	Final	1
Time 0730 ECC/STAT FAX TO 334 567-1538 CD- 41147603537				
Patient Name	Sex	Age (Yr/Mos)		
NATION, MARVIN	M	038/06/04		
Pat Addr				
Date Collected	Date Entered	Date Reported		
09/23/04	09/23/04	/ /	0000	

Clinical Information	
DOB: [REDACTED]	Fasting: Y
Physician ID	Patient ID
WILLIAMS	141669
Account	
Staton Correctional Facility 01308900 Prison Health Services 2690 Marion Spillway Road Elmore, AL 36205-0000 334-567-1548	

TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB
CBC With Differential/Platelet					
White Blood Cell (WBC) Count	8.2		x10E3/uL	4.0 - 10.5	YX
Red Blood Cell (RBC) Count	4.91		x10E6/uL	4.10 - 5.60	YX
Hemoglobin	14.3		g/dL	12.5 - 17.0	YX
Hematocrit	41.4		%	36.0 - 50.0	YX
MCV	84		fL	80 - 98	YX
MCH	29.1		pg	27.0 - 34.0	YX
MCHC	34.6		g/dL	32.0 - 36.0	YX
RDW	13.6		%	11.7 - 15.0	YX
Platelets	194		x10E3/uL	140 - 415	YX
Neutrophils	58		%	40 - 74	YX
Lymphs	31		%	14 - 46	YX
Monocytes	8		%	4 - 13	YX
Eos	2		%	0 - 7	YX
Basos	1		%	0 - 3	YX
Neutrophils (Absolute)	4.8		x10E3/uL	1.8 - 7.8	YX
Lymphs (Absolute)	2.5		x10E3/uL	0.7 - 4.5	YX
Monocytes (Absolute)	0.7		x10E3/uL	0.1 - 1.0	YX
Eos (Absolute)	0.2		x10E3/uL	0.0 - 0.4	YX
Baso (Absolute)	0.1		x10E3/uL	0.0 - 0.2	YX

Lab: YX LabCorp Montgomery Hull Director: Alton Sturtevant, PhD
 543 Hull Street Montgomery, AL 36104-0000

For inquiries, the physician may contact: Branch: 800-659-3324 Lab: 334-263-5745
 Last Page of Report

PA 9-23-04

NATION, MARVIN
ID: 141669

05/25/2004 17:24:04

SINUS BRADYCARDIA
NO OTHER FINDING

D.O.B.: [REDACTED] 38 YEARS
MALE

ER
Dr: SOMNIER
Tech: YB

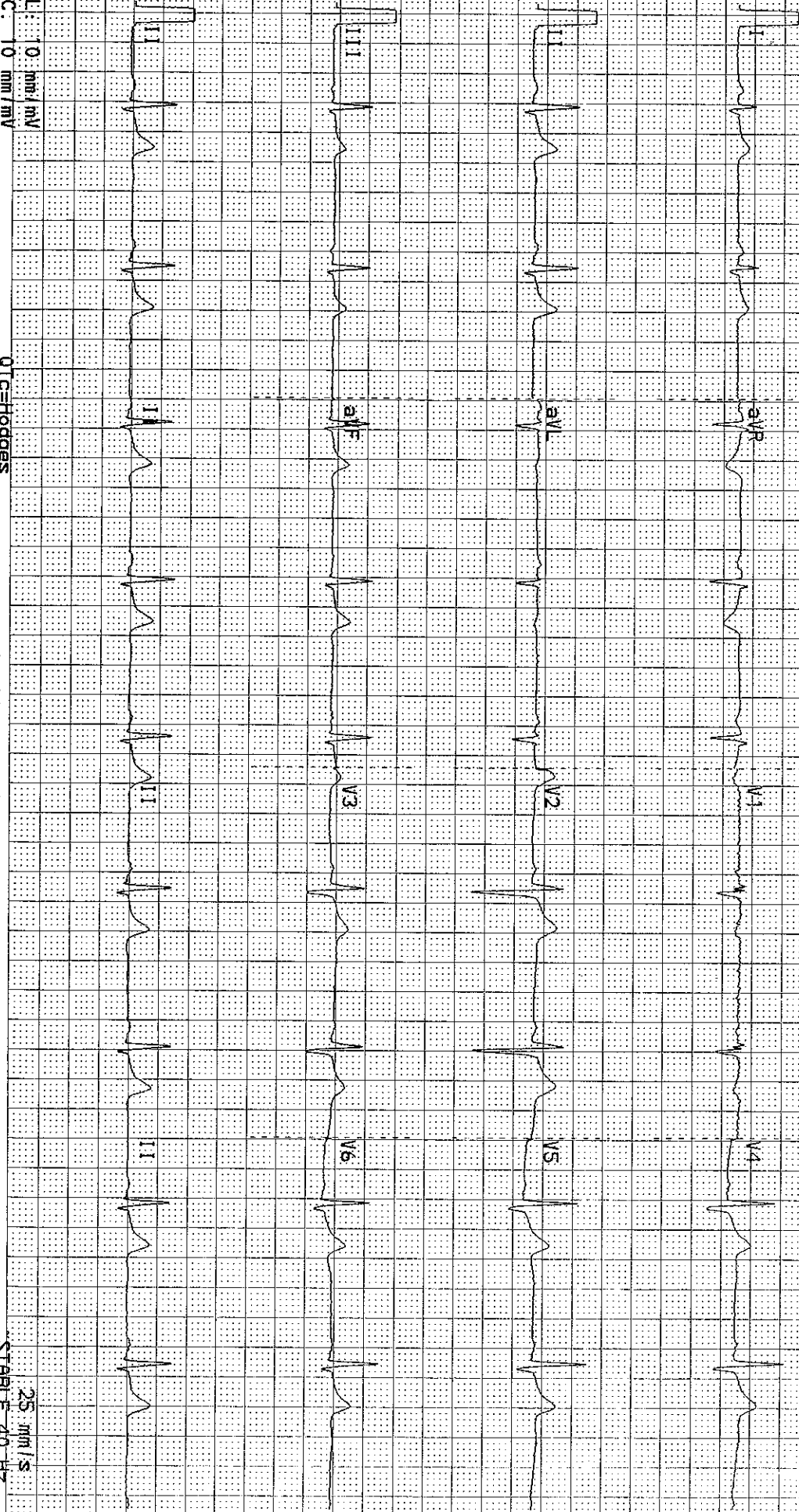
Comment: ECC

Vent. Rate:	56 bpm
RR Interval:	1060 ms
PR Interval:	144 ms
QRS Duration:	94 ms
QT Interval:	412 ms
QTc Interval:	405 ms
QT Dispersion:	44 ms
P-R-T AXIS:	16° 78° 64°

Summary: NORMAL ECG EXCEPT FOR RATE * Unconfirmed Analysis *

inverted T's V1 & V2

6/7/04



L: 10 mm/mV
C: 10 mm/mV

QTc=Hodges

Alt: a 3000 Int: 97/4, 3/25, 4/2, 2/10/03

Serial #10001423

25 mm/s
STABLE 40 HZ
0.401

Laboratory Corporation of America


SPECIMEN 090-684-3176-0	TYPE S	PRIMARY LAB YX	REPORT STATUS COMPLETE	Page #: 1
ADDITIONAL INFORMATION				
ELMORE CORR FAC SRC:NOSE		FASTING: N DOB: [REDACTED]		
PATIENT NAME NATION, MARVIN		SEX M	AGE(YR/MOS.) 38 /	
PT. ADD.:				
DATE OF SPECIMEN 3/30/2004	TIME 11:12	DATE RECEIVED 3/30/2004	DATE REPORTED 4/01/2004	TIME 14:14
937				
TEST		RESULT		LIMITS

CLINICAL INFORMATION CD- 95203901769	
PHYSICIAN ID. SONNIER M	PATIENT ID. 141669
ACCOUNT: STATON CORRECTIONAL FACILITY PRISON HEALTH SERVICES 2690 MARION SPILL WAY ROAD ELMORE AL 36205-0000	
ACCOUNT NUMBER: 01308900	

TEST	RESULT	LIMITS	LAB
Aerobic Bacterial Culture	Final report		YX
Result 1			YX
Methicillin - resistant Staphylococcus aureus			
Heavy growth			
Antimicrobial Susceptibility			YX
***** S = Susceptible; I = Intermediate; R = Resistant *****			
MICS are expressed in micrograms per mL			
Antibiotic	RSLT#1	RSLT#2	RSLT#3
Clindamycin	S		
Erythromycin	R		
Gentamicin	S		
Levofloxacin	R		
Linezolid	S		
Oxacillin	R		
Penicillin	R		
Tetracycline	S		
Trimeth/Sulfameth	S		
Vancomycin	S		

LAB: YX LabCorp Montgomery Hull
 543 Hull Street, Montgomery, AL 36104-0000

DIRECTOR: Alton Sturtevant B PhD

4/6/04


KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME

Nation, Marcus

PRISON ID

141669

DATE SUBMITTED

4/16/02

NPV #4

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
142 HIV ANTIBODY	✓ NP	NEGATIVE (NEG)	
RPR	✓ NP	NON-REACTIVE (NR)	
URINALYSIS	✓		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN	NES	NEGATIVE (NEG)	
GLUCOSE	2+	NEGATIVE (NEG)	
KETONES	NES	NEGATIVE (NEG)	
BILIRUBIN	NES	NEGATIVE (NEG)	
BLOOD	NES	< 5 RBC/MCL	
NITRITE	NES	NEGATIVE (NEG)	
UROBILINOGEN	—	< 1.0 MG/DL	
LEUK. ESTERASE	NES	NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

"A"

These results are unreliable due to the age of the specimen.

"H"

These results are unreliable due to the hemolyzed condition of the specimen.

"A+H"

These results are unreliable due to the age and hemolyzed condition of the specimen.

Gulbert
4-19-02

KILBY CORRECTIONAL FACILITY
PO BOX 11
MT. MEIGS, AL 36057

PATIENT NAME

Nation, Marvin

PRISON ID

141669

DATE SUBMITTED

3-1-01

NPV#17 3-2-01

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY	✓ NR	NEGATIVE (NEG)	
RPR	✓ NR	NON-REACTIVE (NR)	
URINALYSIS	✓ Neg		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN		NEGATIVE (NEG)	
GLUCOSE		NEGATIVE (NEG)	
KETONES		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	
BLOOD		< 5 RBC/MCL	
NITRITE		NEGATIVE (NEG)	
UROBILINOGEN		< 1.0 MG/DL	
LEUK. ESTERASE		NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

SPECIMEN 246-205-0356-0	TYPE S	PRIMARY MB	REPORT STATUS COMPLETE	PAGE 1
ADDITIONAL INFORMATION				
PATIENT NAME NATIM, MARVIN		SEX M	AGE (YR / MOS)	
PT. ADD.:				
DATE OF SPECIMEN 9/03/98	TIME 11:00	DATE RECEIVED 9/03/98	DATE REPORTED 9/04/98	TIME 16:26
			532	

CLINICAL INFORMATION	
PHYSICIAN ID. AN	PATIENT ID. 141669
ACCOUNT: KILBY CORRECTIONAL FACILITY CORRECTIONAL MEDICAL SERVICES P.O. BOX 11 MI. MEIGS AL 36057-0000 ACCOUNT NUMBER = 01302895	

TEST	RESULT	LIMITS	LAB
URINALYSIS, ROUTINE			
URINALYSIS GROSS EXAM			
Specific Gravity	1.025	1.005 - 1.030	MB
pH	6.0	5.0 - 7.5	MB
Urine-Color	Yellow	Yellow	MB
Appearance	Clear	Clear	MB
WBC Esterase	NEG.	Negative	MB
Protein	NEG.	Negative/Trace	MB
Glucose	NEG.	Negative	MB
Ketones	NEG.	Negative	MB
Occult Blood	NEG.	Negative	MB
Bilirubin	NEG.	Negative	MB
Urobilinogen, Semi-Qn	NEG.	0 - 2	MB
Nitrite, Urine	NEG.	Negative	MB
Microscopic Examination			MB
Microscopic follows if indicated.			
▶ Amylase, Serum	179 H U/L	0 - 99	MB
▶ Lipase, Serum	886 H U/L	0 - 189	MB

LAB: MB LABCORP HOLDINGS DIRECTOR: CONTACT LABORATORY
 1801 FIRST AVENUE SOUTH, BIRMINGHAM, AL 35233-0000

LAST PAGE OF REPORT

TA 9/10/98

SPECIMEN 246-205-0356-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	PAGE 1
ADDITIONAL INFORMATION				
PATIENT NAME NATIM, MARVIN		SEX M	AGE (YR./MOS.)	
PT. ADDR.:				
DATE OF SPECIMEN 9/03/98	TIME 11:00	DATE RECEIVED 9/03/98	DATE REPORTED 9/04/98	TIME 16:26
				532

CLINICAL INFORMATION	
PHYSICIAN ID AN	PATIENT ID 141669
ACCOUNT: KILBY CORRECTIONAL FACILITY CORRECTIONAL MEDICAL SERVICES P O. BOX 11 MI. MEIGS AL 36057-0000 ACCOUNT NUMBER = 01302895	

TEST	RESULT	LIMITS	LAB
URINALYSIS, ROUTINE			
URINALYSIS GROSS EXAM			
Specific Gravity	1.025	1.005 - 1.030	MB
pH	6.0	5.0 - 7.5	MB
Urine-Color	Yellow	Yellow	MB
Appearance	Clear	Clear	MB
WBC Esterase	NEG.	Negative	MB
Protein	NEG.	Negative/Trace	MB
Glucose	NEG.	Negative	MB
Ketones	NEG.	Negative	MB
Occult Blood	NEG.	Negative	MB
Bilirubin	NEG.	Negative	MB
Urobilinogen, Semi-Qn	NEG. mg/dL	0 - 2	MB
Nitrite, Urine	NEG.	Negative	MB
Microscopic Examination			MB
Microscopic follows if indicated.			
► Amylase, Serum	179 H U/L	0 - 99	MB
► Lipase, Serum	886 H U/L	0 - 189	MB

LAB: MB LABCORP HOLDINGS DIRECTOR: CONTACT LABORATORY
1801 FIRST AVENUE SOUTH, BIRMINGHAM, AL 35233-0000

LAST PAGE OF REPORT

SPECIMEN 246-205-0356-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	PAGE 1
ADDITIONAL INFORMATION				
PATIENT NAME NATIM, MARVIN		SEX M	AGE (YR./MOS.)	
PT. ADDR.				
DATE OF SPECIMEN 9/03/98	TIME 11:00	DATE RECEIVED 9/03/98	DATE REPORTED 9/04/98	TIME 8:49
		524		

CLINICAL INFORMATION	
PHYSICIAN ID AN	PATIENT ID 141669
ACCOUNT: KILBY CORRECTIONAL FACILITY CORRECTIONAL MEDICAL SERVICES P.O. BOX 11 MT. MEIGS AL 36057-0000 ACCOUNT NUMBER = 01302895	

TEST	RESULT	LIMITS	LAB
URINALYSIS, ROUTINE			
URINALYSIS GROSS EXAM			
Specific Gravity	1.025	1.005 - 1.030	MB
pH	6.0	5.0 - 7.5	MB
Urine-Color	Yellow	Yellow	MB
Appearance	Clear	Clear	MB
WBC Esterase	NEG.	Negative	MB
Protein	NEG.	Negative/Trace	MB
Glucose	NEG.	Negative	MB
Ketones	NEG.	Negative	MB
Occult Blood	NEG.	Negative	MB
Bilirubin	NEG.	Negative	MB
Urobilinogen, Semi-Qn	NEG. mg/dL	0 - 2	MB
Nitrite, Urine	NEG.	Negative	MB
Microscopic Examination			MB
Microscopic follows if indicated.			
► Amylase, Serum	179 H U/L	0 - 99	MB

LAB: MB LABCORP HOLDINGS DIRECTOR: CONTACT LABORATORY
1801 FIRST AVENUE SOUTH, BIRMINGHAM, AL 35233-0000

LAST PAGE OF REPORT

TH
9/8/98

SPECIMEN 236-205-0372-0	TYPE S	PRIMARY LAB MB	REPORT STATUS COMPLETE	PAGE 1
ADDITIONAL INFORMATION				
NPY 32				
DOB: [REDACTED]				
PATIENT NAME NATION, MARVIN		SEX M	AGE (YR./MOS.) 32/ 5	
PI ADD :				
DATE OF SPECIMEN 8/24/98	TIME 8:00	DATE RECEIVED 8/24/98	DATE REPORTED 8/25/98	TIME 8:49
220				

CLINICAL INFORMATION CD- 51261645408
PHYSICIAN ID AN
PATIENT ID 141669
ACCOUNT: KILBY CORRECTIONAL FACILITY CORRECTIONAL MEDICAL SERVICES P.O. BOX 11 MI. MEIGS AL 36057-0000 ACCOUNT NUMBER = 01302895

TEST	RESULT	LIMITS	LAB
CBC WITH DIFFERENTIAL/PLATELET			
White Blood Cell (WBC) Count	6.9 X 10 ⁻³ /uL	4.0 - 10.5	MB
Red Blood Cell (RBC) Count	5.11 X 10 ⁻⁶ /uL	4.10 - 5.60	MB
Hemoglobin	15.2 g/dL	12.5 - 17.0	MB
Hematocrit	43.9 %	36.0 - 50.0	MB
MCV	86 fL	80 - 98	MB
MCH	29.7 pg	27.0 - 34.0	MB
MCHC	34.6 g/dL	32.0 - 36.0	MB
Platelets	185 X 10 ⁻³ /uL	140 - 415	MB
Polys	68 %	40 - 74	MB
Lymphs	24 %	14 - 46	MB
Monocytes	6 %	4 - 13	MB
Eos	2 %	0 - 7	MB
Basos	0 %	0 - 3	MB
Polys (Absolute)	4.7 X 10 ⁻³ /uL	1.8 - 7.8	MB
Lymphs (Absolute)	1.7 X 10 ⁻³ /uL	.7 - 4.5	MB
Monocytes (Absolute)	.4 X 10 ⁻³ /uL	.1 - 1.0	MB
Eos (Absolute Value)	.1 X 10 ⁻³ /uL	.0 - .4	MB
Baso (Absolute)	.0 X 10 ⁻³ /uL	.0 - .2	MB

LAB: MB LABCORP HOLDINGS DIRECTOR: CONTACT LABORATORY
 1801 FIRST AVENUE SOUTH, BIRMINGHAM, AL 35233-0000

LAST PAGE OF REPORT

TD
8/26/98

Nation, Marvin

PRISON ID

141669

DATE SUBMITTED

8-24-98

NPY32825

TEST NAME	RESULT	REFERENCE RANGE	COMMENTS
HIV ANTIBODY	✓ <u>NR</u>	NEGATIVE (NEG)	
RPR	✓ <u>NR</u>	NON-REACTIVE (NR)	
URINALYSIS	✓		
APPEARANCE			
pH		pH 5- pH 6	
PROTEIN	<u>neg</u>	NEGATIVE (NEG)	
GLUCOSE	<u>Trace</u>	NEGATIVE (NEG)	
KETONES	<u>neg</u>	NEGATIVE (NEG)	
BILIRUBIN	<u>neg</u>	NEGATIVE (NEG)	
BLOOD	<u>neg</u>	< 5 RBC/MCL	
NITRITE	<u>neg</u>	NEGATIVE (NEG)	
UROBILINOGEN	<u>—</u>	< 1.0 MG/DL	
LEUK. ESTERASE	<u>neg</u>	NEGATIVE (NEG)	
SPECIFIC GRAVITY		1.016-1.022	

TA 8/26/98

HCX

HEALTHCARE CORRECTIONS
RADIOLOGY SERVICES REQUEST AND REPORTName: Nation, MarionState ID No: 141669DOB: [REDACTED]Race: W/MSex: INSTITUTION: Edmon

NOTE: PERTINENT CLINICAL INFORMATION AND TENTATIVE DIAGNOSIS MUST BE PROVIDED FOR X-RAY EXAMINATION TO BE PERFORMED

Requesting Physician/PA/NP <u>Williams</u>	Date of request <u>10-21-04</u>	Time of request	Routine	Priority	Transportation or special needs
---	------------------------------------	-----------------	---------	----------	---------------------------------

HISTORY/DIAGNOSIS:

Pain

X-RAY REQUEST

ABDOMEN/KUB	FINGERS	NAVICULAR VIEW	SOFT TISSUE STUDIES
ACROMIO-CLAVICULAR JOINTS (W/WO WEIGHT)	FOOT	ORBITS	STERNUM
ANKLE	HAND	OS CALCEI (HEEL)	TEMPORO-MANDIBULAR JOINTS
CERVICAL SPINE	<u>✓ HIP Right</u>	PELVIS	THORACIC SPINE
CHEST PA / LATERAL	HUMERUS	RADIUS/ULNA	TIBIA/FIBULA
COCCYX	KNEE	RIBS	TOES
CONE DOWN SELLA TURCICA	<u>✓ LUMBAR SPINE</u>	SACRO-ILIAC JOINTS	WRIST
ELBOW	MANDIBLE	SCAPULA	ZYGOMA
FACIAL BONES	MAXILLA	SHOULDER	ZYGOMATIC ARCH
FEMUR	NASAL BONES	SKULL	

Nation

REPORT

RIGHT HIP: The examination shows no evidence of recent fracture or other significant bony abnormality.

IMPRESSION: NEGATIVE STUDY.

LUMBAR SPINE: The vertebrae are well aligned and show no evidence of any fracture or any destructive bone disease.

IMPRESSION: NORMAL STUDY.

D & T: 11-11-04 Maurice H Rowell/rr Board Certified Radiologist (Signature on File)

11-12-04J. Kerbetz R.T.
X-RAY TECHNOLOGIST'S NAME (PRINT)J. Kerbetz
X-RAY TECHNOLOGIST'S SIGNATURE11-10-04
DATE, TIME EXAM PERFORMED

RADIOLOGIST'S NAME (PRINT)

RADIOLOGIST'S SIGNATURE

DATE SIGNED

X-ray, Requisition and Re.

Patient Name	Date of Request	Requested By	Patient Status
Limestone	8/1/03	[Signature]	Outpatient
Examination Requested C-spine to include C-7 and T1 with Swimmer's view			
Clinical Diagnosis As recommended by Radiologist see report of 7/25			
X-Ray Number	Date of X-Ray	Date of APD Skin Test	
	8-1-03		
Report of Findings			

NATION, MARVIN ID 141669

SINGLE VIEW SWIMMER'S VIEW OF CERVICAL SPINE 08/01/03
COMPARISON: 07/25/03

FINDINGS: ALIGNMENT OF THE CERVICOTHORACIC JUNCTION APPEARS
NORMAL. LAMINAE ALIGN NORMALLY. NO FRACTURES ARE DETECTED.

IMPRESSION: NORMAL ALIGNMENT OF THE CERVICOTHORACIC
JUNCTION.

RP
John P. Waldo, M.D.
Radiology Associates of Alabama, P.C.

[Signature]

[Signature]
8/15/03

M.D.

Physician's Signature

Patient's Last Name	First	Middle	Date of Birth	R/S	ID Number
Nation	Marvin		[Redacted]	WM	141669

X-Ray Requisition and Report

X-Ray, Requisition and Report

Patient's Name <i>Limestone</i>	Date of Request <i>7/25/03</i>	Requested By <i>SMITH</i>	Patient Status <input type="radio"/> Outpatient
Examination Requested <i>C-spine XR</i>			

Clinical Diagnosis

Had a 125 lb weight bar hit the back of his neck - Now has pain and stiffness of neck.

X-Ray Number	Date of X-Ray <i>7-25-03</i>	Date of PPD Skin Test
--------------	---------------------------------	-----------------------

Report of Findings

NATION, MARVIN ID 141669

CERVICAL SPINE THREE VIEWS 07/25/03

FINDINGS: THE INFERIOR HALF OF C7 AND THE TOP OF T1 IS NOT VISUALIZED ON THE LATERAL VIEW. ALIGNMENT OF THE CERVICAL SPINE IS WITHIN NORMAL LIMITS. I SEE NO EVIDENCE OF FRACTURE INVOLVING THE VISUALIZED CERVICAL SPINE. PRESERVATION OF THE INTERVERTEBRAL DISC SPACES IS MAINTAINED. I SEE NO EVIDENCE OF PREVERTEBRAL SOFT TISSUE SWELLING.

IMPRESSION: NO SIGNIFICANT ABNORMALITY IS SEEN ON LIMITED VIEWS OF THE CERVICAL SPINE. THE INFERIOR HALF OF C7 AND THE TOP OF T1 IS NOT SEEN ON CURRENT EXAM. SWIMMER'S VIEW IS FURTHER NEEDED TO COMPLETE RADIOGRAPHIC EVALUATION OF THE CERVICAL SPINE.

W BEN ABBOTT, MD/rp

WBA
AS
8/1/03

M.D.

Physician's Signature

Patient's Last Name <i>Nation</i>	First <i>Marvin</i>	Middle	Date of Birth <i>[REDACTED]</i>	R/S <i>141669</i>	ID Number <i>141669</i>
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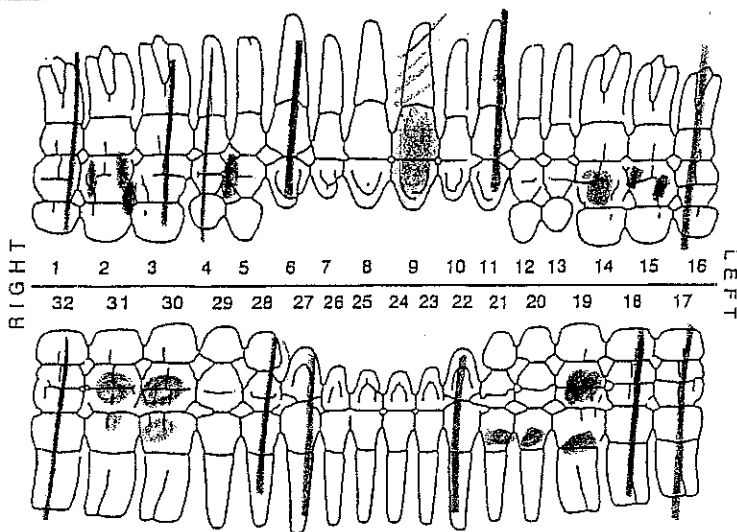
X-Ray Requisition and Report

WM

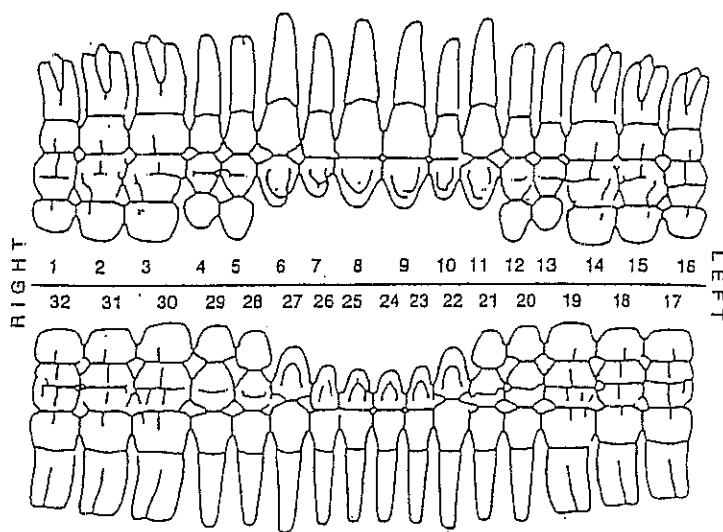
Dental Treatment Record

Name: <u>NATIONS, MARVIN</u>	ID #: <u>141669</u>	Race: <u>W</u>	DOB: <u>[REDACTED]</u>
------------------------------	---------------------	----------------	------------------------

Dental Examination



Restoration and Treatments

Date of Initial Examination: 4-15-02

Initial Classification:

Oral Pathology:

Gingivitis

Vincent's Infection

Stomatitis

Other Findings

Occlusion

Roentgenograms:

Periapical

Bitewing

Panorex

Tooth

Priority List

1 = P
2 = P
3 = P

Health Questionnaire

Are you in good health?	<input checked="" type="radio"/> Yes <input type="radio"/> No	Acquired Immune Deficiency (AIDS/HIV)?	<input type="radio"/> Yes <input checked="" type="radio"/> No
Allergies	<input type="radio"/> Yes <input checked="" type="radio"/> No	Gastrointestinal disorders	<input checked="" type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input checked="" type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input checked="" type="radio"/> No
Asthma or other respiratory problems	<input type="radio"/> Yes <input checked="" type="radio"/> No	Heart disease or murmur	<input type="radio"/> Yes <input checked="" type="radio"/> No
Blood pressure conditions	<input type="radio"/> Yes <input checked="" type="radio"/> No	Hepatitis	<input type="radio"/> Yes <input checked="" type="radio"/> No
Diabetes	<input type="radio"/> Yes <input checked="" type="radio"/> No	Kidney problems	<input type="radio"/> Yes <input checked="" type="radio"/> No
Epilepsy	<input type="radio"/> Yes <input checked="" type="radio"/> No	Reactions to anesthesia or medications	<input type="radio"/> Yes <input checked="" type="radio"/> No
Excessive bleeding after surgery	<input type="radio"/> Yes <input checked="" type="radio"/> No	Rheumatic fever	<input type="radio"/> Yes <input checked="" type="radio"/> No
Fainting	<input type="radio"/> Yes <input checked="" type="radio"/> No	Taking any medication	<input type="radio"/> Yes <input checked="" type="radio"/> No
Pregnant?	<input type="radio"/> Yes <input checked="" type="radio"/> No	Thyroid conditions	<input type="radio"/> Yes <input checked="" type="radio"/> No
Tuberculosis	<input type="radio"/> Yes <input checked="" type="radio"/> No	Other conditions	<input type="radio"/> Yes <input checked="" type="radio"/> No

Dental Treatment Record



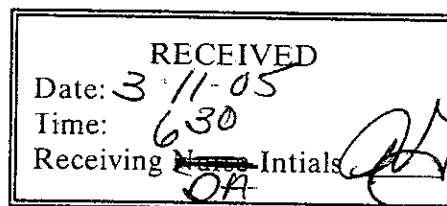
PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: MARVIN NATION Date of Request: 3-9-05
 ID # 141669 Date of Birth: [REDACTED] Location: Elmore A-1-100
 Nature of problem or request: I Need to see the Dentist as soon as possible, my tooth Broke off.

Marvin Nation
Signature

DO NOT WRITE BELOW THIS LINE

Date: 3/11/05
 Time: 6:30 AM PM
 Allergies:



(S)ubjective: Tooth broke need to see Dentist

(O)bjective (V/S): T: P: R: BP: WT:

Dental screening
 (A)ssessment: Request reviewed

(P)lan: We will get you in as soon as we can
Thank you

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Anne Harrison
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

CORRECTIONAL MEDICAL SERVICES DENTAL TREATMENT RECORD

NAME: <u>Nation, Marvin</u>		ID: <u>141669</u>	RACE: <u>W</u>	DOB: <u>[REDACTED]</u>
-----------------------------	--	-------------------	----------------	------------------------

DENTAL EXAMINATION		RESTORATION AND TREATMENTS	

Date of Initial Examination: <u>3-1-01</u>		<table border="1"> <thead> <tr> <th>TOOTH</th> <th>PRIORITY LIST</th> </tr> </thead> <tbody> <tr><td></td><td><u>t = P</u></td></tr> <tr><td></td><td><u>g = F</u></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </tbody> </table>	TOOTH	PRIORITY LIST		<u>t = P</u>		<u>g = F</u>														
TOOTH	PRIORITY LIST																					
	<u>t = P</u>																					
	<u>g = F</u>																					
Initial Classification:																						
Oral Pathology:																						
Gingivitis																						
Vincent's Infection																						
Stomatitis																						
Other Findings																						
Occlusion																						
Roentgenograms:																						
Periapical																						
Bitewing																						
Panorex																						

HEALTH QUESTIONNAIRE		YES	NO			YES	NO
Are you in good health?		<input checked="" type="checkbox"/>		Acquired Immune Deficiency (AIDS/HIV)?			<input checked="" type="checkbox"/>
Allergies			<input checked="" type="checkbox"/>	Gastrointestinal disorders		<input checked="" type="checkbox"/>	
Anemia			<input checked="" type="checkbox"/>	Glaucoma			<input checked="" type="checkbox"/>
Asthma or other respiratory problems			<input checked="" type="checkbox"/>	Heart disease or murmur			<input checked="" type="checkbox"/>
Blood pressure conditions			<input checked="" type="checkbox"/>	Hepatitis			<input checked="" type="checkbox"/>
Diabetes			<input checked="" type="checkbox"/>	Kidney problems			<input checked="" type="checkbox"/>
Epilepsy			<input checked="" type="checkbox"/>	Reactions to anesthetics or medications			<input checked="" type="checkbox"/>
Excessive bleeding after surgery			<input checked="" type="checkbox"/>	Rheumatic fever			<input checked="" type="checkbox"/>
Fainting			<input checked="" type="checkbox"/>	Taking any medication			<input checked="" type="checkbox"/>
Pregnant?			<input checked="" type="checkbox"/>	Thyroid conditions			<input checked="" type="checkbox"/>
Tuberculosis			<input checked="" type="checkbox"/>	Other conditions		<input checked="" type="checkbox"/>	

ECC



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: MARVIN NATION Date of Request: 11-30-04
 ID # 141669 Date of Birth: [REDACTED] Location: A-1-100
 Nature of problem or request: I need to see the Dentist, one
of my teeth he was working on Broke off.

Marvin Nation
Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

RECEIVED	
Date:	<u>12/1/04</u>
Time:	<u>10⁰⁰ pm</u>
Receiving Nurse Initials	<u>AK</u>

*see
Dentist*

(S)ubjective: Dental screening

(O)bjective (V/S): T: P: R: BP: WT:

Tooth broke

(A)ssessment: Request reviewed

(P)lan: Does the tooth hurt? Is this the
tooth the root canal was done on?
Got made.

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN
 CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

Erne Harrison
SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



**PRISON HEALTH SERVICES, INC.
SICK CALL REQUEST**

Print Name: MARVIN NATION Date of Request: 1-29-04
 ID # 141669 Date of Birth: [REDACTED] Location: 11-53-T
 Nature of problem or request: I need to ~~see~~ have my
Teeth cleaned please.
PS and if you AND DR Tony THANK YOU
have Time I could use A couple of filling
Just call me I'll Be ready any Time MARVIN NATION
Thank you. Signature

DO NOT WRITE BELOW THIS LINE

Date: / /
 Time: AM PM
 Allergies:

<p align="center">RECEIVED</p> <p>Date: _____</p> <p>Time: _____</p> <p>Receiving Nurse Initials _____</p>

(S)ubjective:

(O)bjective

(A)ssessment:

(P)lan:

Refer to: MD/PA Mental Health Dental Daily Treatment Return to Clinic PRN

CIRCLE ONE

Check One: ROUTINE () EMERGENCY ()

If Emergency was PHS supervisor notified: Yes () No ()

Was MD/PA on call notified: Yes () No ()

SIGNATURE AND TITLE

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT



HEALTH SERVICES REQUEST FORM

NOV 19 2002

Print Name: MARVIN NATION Date of Request: 11-18-02
ID#: 141669 Date of Birth: [REDACTED] Housing Location: 6-B-28T
Nature of problem or request: I need to have a tooth filled
AS soon AS possible
Thank you
Marvin Nation
Marvin Nation
Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective: Red 11/20/02

12/10

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: _____ Title: _____ Date: _____ Time: _____



HEALTH SERVICES REQUEST FORM

NOV 08 2002

Print Name: MARVIN NATION Date of Request: 11-07-02

ID#: 141669 Date of Birth: [REDACTED] Housing Location: 6-28-Top

Nature of problem or request: I NEED TO SEE A Dentist,
one of my Teeth has broke off AND I am in pain.
Thank you

Marvin Nation
Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: _____ Title: _____ Date: _____ Time: _____

*Call
Self
11/1/8.*



NOV 08 2002

HEALTH SERVICES REQUEST FORM

Print Name: MARVIN NATION Date of Request: 11-07-02

ID#: 141669 Date of Birth: [REDACTED] Housing Location: 1e-28-Top

Nature of problem or request: I NEED TO SEE A Dentist,

one of my Tooth's has broke off and I am in pain.

Thank you

Marvin Nation
Sign here for consent to be treated by health staff for the condition described

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ I _____

Assessment:

Plan:

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: _____ Title: _____ Date: _____ Time: _____

call
Self
11/1/02

**CORRECTIONAL MEDICAL SERVICES
HEALTH SERVICES REQUEST FORM**

Print Name: MARVIN NATION Date of Request: 9-23-98

ID #: 141669 Date of Birth: [REDACTED] Housing Location: M-146

Nature of problem or request: I NEED TO SEE THE DENTIST

AS SOON AS POSSIBLE (Thank you for your time)

I consent to be treated by health staff for the condition described.

Marvin Nation
SIGNATURE

PLACE THIS SLIP IN MEDICAL BOX OR DESIGNATED AREA
DO NOT WRITE BELOW THIS AREA

HEALTH CARE DOCUMENTATION

Subjective:

Objective: BP _____ P _____ R _____ T _____

Assessment:

Plan:
R4C
LXX

Refer to: _____ PA/Physician _____ Mental Health _____ Dental

Signature: M. Squire Title: RDH Date: 9-24-98 Time: _____

PROBLEM LIST

Name Nation. Marvin

ID # 141669 / wmc

DOB [REDACTED]

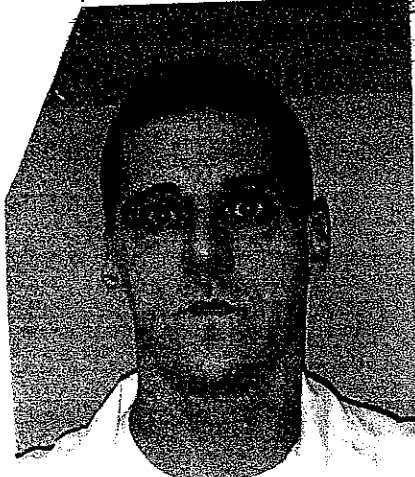
Medication Allergies

NKA

[illegible]

01/94

4/15/2002



141669 NATION, MARVIN K

NAME: NATION, MARVIN

AIS#: 141669 DOB: [REDACTED] R/S: W/M

HT: 6'1" WT: 175 HAIR: BRO

EYES: BRO SS#: [REDACTED]

CUSTODY: MED AKA: [REDACTED]

CURRENT AGE: 36 EDUCATION LEVEL: 12TH

OF ESCAPES: — JOB SKILL: —

CARS/TATOOS: [REDACTED]

SENTENCE DATE: 6-87 ADMIT DATE: 6-87 RELEASE DATE: (min) 3-13-2010

TOTAL TERM: 28 1/2 YR COUNTIES CONVICTED: HOUSTON DALE (lng) 4-12-2014 COFFEE

CRIMES: BURG III X 4 / TOP / ROB T

EMERGENCY ADDRESS: TRUDY NATION (MOTHER) 598-3135

116 DOGWOOD ST. DALEVILLE, AL.

FAMILY MEMBERS:

SPOUSE: DIANN NATION M-GRANDPARENTS: N/A

719 STANHOPE DR. H'VILLE, AL. 534-2575

MOTHER: S.E.

FATHER: ROBERT NATION P-GRANDPARENTS: N/A

ORANGE, TX.

SIBLINGS:

ROBERT NATION - S.E.

RONNIE " - S.E.

BEALINDA " - S.E.

CHILDREN: BRANDON KENNEDY (AGE 16) w/ WIFE

COREY KENNEDY (AGE 13)

NICHOLAS NATION (AGE 8)



INFIRMARY ADMISSION

INMATE NAME: Nation, Marvin DOC# 141669

ADMISSION DATE: 9-22-04

ADMITTING DIAGNOSIS: Fx facial bones

ADMITTING PHYSICIAN: W. Williams, MD

ESTIMATED LENGTH OF STAY: _____



INFIRMARY PATIENT CARE PLAN

Name: <i>Nation, Marvin</i>		Diagnosis:	
DOC #: <i>14166 a</i>		Operations:	
Admit Date: <i>9/22/04</i>		Special Procedures:	
Admit Weight:		Allergies: <i>NKA</i>	

Weight: B/P & TPR BID _____ TID _____ Q 4 hours _____ Daily _____ Neuro Checks: Other:	Diet <i>liquid or soft</i> 1 <input type="checkbox"/> 0 <input type="checkbox"/> Fluids: Encourage/Restrict 7-3 3-11 11-7 NPO:		Code Blue Y N Living Will Y N Power/Attorney Y N
	Foley Cath: _____ Straight Cath: _____ Treatments: <i>leg Δ of pm @ leg x 7 days</i> Glucose Monitoring:		Medications: ① Vicodin T or P <i>q 4-6 hrs per pain x 7 days</i> ② Percocet # 5 Tylenol <i>650mg po q 4-6 hrs per pain x 7 days</i> ③ Halcid Tylenol # 5 Tylenol <i>breakthrough pain q 6 hrs prn x 7 days</i> ④ Milt Savas + po TID <i>x 7 days</i>
	Respiratory Therapy: constant/prn cannula/mask Oxygen 1/pm Maximist Treatments:		
	Radiology: Preps: Y N		
	Laboratory: Tests:		
Dressings/Treatments: <i>① leg Δ of pm x 7 days</i>		PRN Medications: <i>See above</i>	



DEPARTMENT OF CORRECTIONS

INPATIENT HISTORY AND PHYSICAL

CHIEF COMPLAINT ① jaw & ② face pain, c/o "my teeth hurt"Hx OF PRESENT ILLNESS MVA on 9/21/04

PREVIOUS ILLNESS _____

CURRENT MEDICATIONS AmoxicillinALLERGIES NKA

Habits:

Smoking _____

Alcohol _____

Drugs _____

Family Hx:

T.B. _____

Diabetes _____

Cancer _____

Hypertension _____

Other _____

BP _____

T _____

P _____

R _____

	Normal		Abnormal
1		Head, Face & Scalp	✓
2		Mouth & Throat	✓
3		Ears & Eardrums	
4		Eyes & Pupils	
5		Chest & Lungs	
6		Cardiovascular	
7		Abdomen, including Hernia	
8		Anus & Rectum	
9		Ext Genitalia	
10		Skin	
11		Breast	
12		Upper Extremities	
13		Lower Extremities (+)	injury
14		Spine & Musculoskeletal	

REMARKS _____

DIAGNOSIS _____

Date: _____

Examining Physician: _____

INMATE NAME (LAST FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
<u>Nation, Marcus</u>	<u>144/669</u>	<u>[REDACTED]</u>	<u>WM</u>	<u>ECC</u>

PRISON HEALTH SERVICES, INC.

YEARLY HEALTH EVALUATION

I. HISTORY - (LPN or RN)	YES	NO	COMMENT(S)
Weight Change (greater 15 lbs.) (Compare Weight Below)		✓	
Persistent Cough		✓	Last weight at least 6 months ago
Chest Pain		✓	
Blood in Urine or Stool		✓	
Difficult Urination		✓	
Other Illnesses (Details)		✓	
Smoke, Dip or Chew	✓		
ALLERGIES		✓	

Weight 197 Temp 97.2 Pulse 72 Resp 18 Blood Pressure 122/74

Eye Exam 20/20 OD 20/20 OS 20/20 OU

If greater than > 140/90, repeat in 1 hour.

Refer to M.D. if remains > 140/90.

II. TESTING - (LPN or RN)	RESULTS
Tuberculin Skin Test (q yr)	Date given <u>5/25/04</u> Site <u>LCA</u>
Past Positive TB Skin Test →	Read on <u>5-27-04</u> Results <u>0</u> mm
(Chest x-ray if clinical symptoms)	Survey Completed <u>N/A</u>
RPR (q 3 yrs)	Date <u>4/16/02</u> Results <u>NR</u>
EKG (baseline at 35, over 45 q 3 yrs)	<u>5-25-04</u> <u>normal</u>
Cholesterol (at 35 then q 5 yrs)	<u>5-27-04</u>
Tetanus/Diphtheria (q 10 yrs)	Last Given <u>1998</u> Due <u>2008</u>
(if done today)	Site given _____ Dose _____ Lot # _____
Optometry Exam (@ 50 if not already seen)	<u>3/14/03</u>
Mammogram	Date <u>N/A</u> Results _____
(females @ 40, q 2 yrs/other M.D. order)	

III. PHYSICAL RESULTS - (RN, Mid-Level, M.D.)

Heart	<u>Reg R + R</u>
Lungs	<u>Bilaterally clear</u>
Breast Exam	<u>WNL</u>
Rectal (yearly after 45)	Results <u>N/A</u>
with Hemocult	Results <u>N/A</u>
Pelvic and PAP (q 1 yr)	Date <u>N/A</u> Results _____

Facility Elmore Nurse Signature J. L. ... Date 5/25/04

M.D. or Mid-Level Signature J. ... Date 7/26/04

INMATE NAME	AGE	DOB	RACE/SEX
<u>Nathan Martin</u>	<u>14/6/69</u>	<u>[REDACTED]</u>	<u>384/0 W/M</u>



DEPARTMENT OF CORRECTIONS

**KITCHEN CLEARANCE
PHYSICAL ASSESMENT**

	YES	NO
ANY OPEN SORES OR RASHES ON HANDS, ARMS, FACE & NECK	_____	<input checked="" type="checkbox"/>
TB TEST CURRENT	<input checked="" type="checkbox"/>	_____
DOES PT. SHOW ANY OBVIOUS SIGNS OF ANY OTHER DISEASE	_____	<input checked="" type="checkbox"/>

OTHER: _____

THIS PATIENT HAS BEEN INFORMED OF THE NEED FOR THE FOLLOWING:

PROPER HANDWASHING, NOT TO HANDLE FOOD WHILE SICK, SEEK MEDICAL
EVALUATION WHEN NECESSARY AND TO NOTIFY THE DIETARY SERVICES SHIFT
SUPERVISOR OF ANY ILLNESS.

MEDICAL AUTHORITY: M. BarnettDATE: 5-25-04

I attest that the above statement is true to the best of my knowledge.

PATIENT SIGNATURE: L. M. HarrisonDATE: 5-25-04

EXPIRATION DATE: _____

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	Race/Sex	FAC.
<u>Matthew Harrison</u>	<u>141669</u>	<u>[REDACTED]</u>	<u>W/M</u>	<u>Elmore</u>

TechCare**Annual Health & TB Screening Appointment**

4/29/2003

Name **NATION, MARVIN K**DOC # **141669**

Birth Date [REDACTED]

Appointment Date **4/15/2003****TB Screening Data**

Date Given	4/25/2003
Site Given	Left Arm
Lot #	00661P
Nurse Administering	JRT
Date Read	4/27/2003
Size in MM	0
Nurse Reading	JRT
Previous Positive	No

Medical Data

Current Weight	201
Previous Weight	200
Height	
Blood Pressure	
Recent Chest Pain	No
Kitchen Clearance	No
Productive Cough	No
Any Bleeding	No
Diabetic	No
Diabetic Condition	N/A
Prosthetic	No

Emergency Contact Data

Name
Phone
Address

Reviewer Signature: _____



Inmate Food Service Worker Clearance

Medical Record Review:

☐ Yes ☒ No Past history of hepatitis
☒ Yes ☒ No TB test current *April 10*
☒ Yes ☒ No TB test negative

If history of positive TB test, verified completed treatment: _____

Date _____

Physical Assessment

☐ Yes ☒ No Open sores or rashes on hands, arms, face and neck
☐ Yes ☒ No Has diarrhea
☐ Yes ☒ No Has a cough
☒ Yes ☐ No Lungs clear to auscultation
☐ Yes ☒ No Signs and symptoms of other contagious diseases

Specify: _____

This inmate's Medical Record has been reviewed and he/she has been examined.

He/she ☒ IS ☐ IS NOT medically cleared for duty as a food service worker.

Signature _____

E. Roberts Jr.

Date _____

8/26/02

Name:

ID # / DOB:

Location:

MARVIN NATION

141669

LCF

Inmate Food Service Worker Clearance

NAPHCARE
MEDICAL HISTORY AND SCREENING

Institution

Inmate Name: NATION MARVINID #: 141669Race: WMDOB: [REDACTED]

INMATE QUESTIONNAIRE		(circle one)	CURRENT MEDICAL CONDITIONS (✓ terms that apply)	
1	Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Unconscious <input type="checkbox"/>	Skin Infection <input type="checkbox"/>
2	Have you fainted or had a head injury in the past 6 months?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Disoriented <input type="checkbox"/>	Restricted Mobility <input type="checkbox"/>
3	Have you been seen by a doctor in the past 6 months?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Intoxicated <input type="checkbox"/>	Skin Rash <input type="checkbox"/>
4	Do you wear glasses or contact lenses?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Lesions <input type="checkbox"/>	Jaundice <input type="checkbox"/>
5	Do you have prosthesis, splint, crutches, cast or brace that you will need while here?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Obvious Pain <input type="checkbox"/>	Needle Marks <input type="checkbox"/>
6	Do you drink wine, beer or whiskey? How often _____ How much _____ Last time _____	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Bruises <input type="checkbox"/>	Swollen Glands <input type="checkbox"/>
7	Have you had seizures or blackouts when you stop drinking?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Fever <input type="checkbox"/>	Active Cough <input checked="" type="checkbox"/>
8	Do you use drugs? Type _____ How often _____ Last time _____	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Nausea <input type="checkbox"/>	Vaginal/Penile Discharge <input checked="" type="checkbox"/>
9	Have you had withdrawal problems when you stop taking drugs?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Uses Tobacco <input type="checkbox"/>	Dental Problems <input checked="" type="checkbox"/>
10	Are you currently detoxing? If yes, from what substance? _____	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	MEDICAL HISTORY (✓ terms that apply)	
11	Do you have any medical problems we should know about?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Frequent Diarrhea <input type="checkbox"/>
12	Have you been in this facility before? <u>Yes</u>	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Genital Sores <input type="checkbox"/>
13	Are you covered by medical insurance or a benefits program?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Seizure Disorder <input type="checkbox"/>	V.D. <input type="checkbox"/>
			Asthma <input type="checkbox"/>	Hepatitis <input type="checkbox"/>
			Special Diet <input type="checkbox"/>	HIV+ <input type="checkbox"/>
			Heart Condition <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>
			Hypertension <input type="checkbox"/>	Persistent Sore Throat <input type="checkbox"/>
			Stomach Ulcer <input type="checkbox"/>	Dental Problems <input type="checkbox"/>
			Cancer <input type="checkbox"/>	Surgeries <input checked="" type="checkbox"/>
			Sickle Cell Anemia <input type="checkbox"/>	Chest Pain <input type="checkbox"/>
			Emphysema <input type="checkbox"/>	Jaundice <input type="checkbox"/>
MENTAL HEALTH			TB HISTORY	
14	Have you ever been hospitalized or treated for psychiatric problem?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Ever treated with TB drugs? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
15	Have you ever considered or attempted suicide?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Previous PPD test? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
16	Are you feeling depressed or extremely sad?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Previous Positive Reaction? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
17	Do you want to hurt yourself or someone else?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	If positive result: When _____ Where _____	
18	Are you hearing voices? If yes, what are they saying?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Chronic Cough/Blood <input type="checkbox"/> Fever <input type="checkbox"/>	
			Recent Weight Loss <input type="checkbox"/> Night Sweats <input type="checkbox"/>	
			Recent Appetite Loss <input type="checkbox"/> Fatigue <input type="checkbox"/>	
FEMALE INMATES ONLY			MEDICATIONS	
19	Are you pregnant? <u>IMP</u>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	Current Medications: <u>[Signature]</u>	
20	Do you use birth control? Type _____	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21	Have you recently had a baby, miscarriage or abortion?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
Comments: (Explain "Yes" Responses) <u>Half stomach removed</u> <u>9/6</u>				
VITAL SIGNS			ALLERGIES	
HT <u>6'4"</u> WT <u>209</u> BP <u>104/93</u>			Medication Allergies: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Pulse <u>88</u> Resp <u>18</u> Temp _____			Type: _____	
			Other Allergies: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
			Type: _____	
DISPOSITION				
Referrals: _____ None _____		Placement: _____		
_____ Emergency Room (Pre-booking injury)		_____ Infirmary		
_____ Emergency Room (Acute condition)		_____ Detoxification Setting		
_____ Physician		_____ General Population		
_____ Sick Call		_____ Other		

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals. I understand that any medications not picked up within 30 days of release will be destroyed.

Inmate Signature: Marvin NationSCREENED BY: R.T.DATE: 4/15/02

TIME: _____

REVIEWED BY: _____

DATE: _____

TIME: _____

Inmate Food Service Worker Clearance

Medical Record Review:

☐ Yes ☒ No Past history of hepatitis
☒ Yes ☐ No TB test current
☐ Yes ☐ No TB test negative

If history of positive TB test, verified completed treatment: _____ Date _____

Physical Assessment

☐ Yes ☒ No Open sores or rashes on hands, arms, face and neck
☐ Yes ☒ No Has diarrhea
☐ Yes ☒ No Has a cough
☒ Yes ☐ No Lungs clear to auscultation
☐ Yes ☒ No Signs and symptoms of other contagious diseases

Specify: _____

This inmate's Medical Record has been reviewed and he/she has been examined.

He/she ☒ IS ☐ IS NOT medically cleared for duty as a food service worker.

Signature

Alt Smith

Date

6/15/02

Name:

ID # / DOB:

Location:

CORRECTIONAL MEDICAL SERVICE
MEDICAL HISTORY AND SCREENING

Inmate Name:

Nation Marvin ID #: 141669

Race:

C

DOB:

Institution

[REDACTED]

INMATE QUESTIONNAIRE			(circle one)	CURRENT MEDICAL CONDITIONS (✓ terms that apply)	
1. Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes	<input checked="" type="radio"/> No		Unconscious	Skin Infection <input checked="" type="checkbox"/>
2. Have you fainted or had a head injury in the past 6 months?	Yes	<input checked="" type="radio"/> No		Disoriented	Restricted Mobility <input checked="" type="checkbox"/>
3. Have you been seen by a doctor in the past 6 months?	<input checked="" type="radio"/> Yes	<input type="radio"/> No		Intoxicated	Skin Rash <input checked="" type="checkbox"/>
4. Do you wear glasses or contact lenses?	Yes	<input checked="" type="radio"/> No		Lesions	Jaundice <input checked="" type="checkbox"/>
5. Do you have prosthesis, splint, crutches, cast or brace that you will need while here?	Yes	<input checked="" type="radio"/> No		Obvious Pain	Needle Marks <input checked="" type="checkbox"/>
6. Do you drink wine, beer or whiskey? How often <u>every day</u> How much <u>3 cups</u> Last time _____	<input checked="" type="radio"/> Yes	<input type="radio"/> No		Bruises	Swollen Glands <input checked="" type="checkbox"/>
7. Have you had seizures or blackouts when you stop drinking?	Yes	<input checked="" type="radio"/> No		Fever	Active Cough <input checked="" type="checkbox"/>
8. Do you use drugs? Type _____ How often _____ Last time _____	Yes	<input checked="" type="radio"/> No		Nausea	Vaginal/Penile Discharge <input checked="" type="checkbox"/>
9. Have you had withdrawal problems when you stop taking drugs?	Yes	<input checked="" type="radio"/> No		Uses Tobacco <input checked="" type="checkbox"/>	Dental Problems <input checked="" type="checkbox"/>
10. Are you currently detoxing? If yes, from what substance? _____	Yes	<input checked="" type="radio"/> No		MEDICAL HISTORY (✓ terms that apply)	
11. Do you have any medical problems we should know about?	Yes	<input checked="" type="radio"/> No		Arthritis <input checked="" type="checkbox"/>	Frequent Diarrhea <input checked="" type="checkbox"/>
12. Have you been in this facility before? <u>1998</u>	<input checked="" type="radio"/> Yes	<input type="radio"/> No		Diabetes <input checked="" type="checkbox"/>	Genital Sores <input checked="" type="checkbox"/>
13. Are you covered by medical insurance or a benefits program?	Yes	<input checked="" type="radio"/> No		Seizure Disorder <input checked="" type="checkbox"/>	V D <input checked="" type="checkbox"/>
MENTAL HEALTH				Asthma <input checked="" type="checkbox"/>	Hepatitis <input checked="" type="checkbox"/>
14. Have you ever been hospitalized or treated for psychiatric problem?	Yes	<input checked="" type="radio"/> No		Special Diet <input checked="" type="checkbox"/>	HIV+ <input checked="" type="checkbox"/>
15. Have you ever considered or attempted suicide?	Yes	<input checked="" type="radio"/> No		Heart Condition <input checked="" type="checkbox"/>	Tuberculosis <input checked="" type="checkbox"/>
16. Are you feeling depressed or extremely sad?	Yes	<input checked="" type="radio"/> No		Hypertension <input checked="" type="checkbox"/>	Persistent Sore Throat <input checked="" type="checkbox"/>
17. Do you want to hurt yourself or someone else?	Yes	<input checked="" type="radio"/> No		Stomach Ulcer <input checked="" type="checkbox"/>	Dental Problems <input checked="" type="checkbox"/>
18. Are you hearing voices? If yes, what are they saying?	Yes	<input checked="" type="radio"/> No		Cancer <input checked="" type="checkbox"/>	Surgeries <input checked="" type="checkbox"/>
FEMALE INMATES ONLY				Sickle Cell Anemia <input checked="" type="checkbox"/>	Chest Pain <input checked="" type="checkbox"/>
19. Are you pregnant? LMP _____	Yes	<input checked="" type="radio"/> No		Emphysema <input checked="" type="checkbox"/>	Jaundice <input checked="" type="checkbox"/>
20. Do you use birth control? Type _____	Yes	<input checked="" type="radio"/> No		TB HISTORY	
21. Have you recently had a baby, miscarriage or abortion?	Yes	<input checked="" type="radio"/> No		Ever treated with TB drugs? <input checked="" type="radio"/> Yes <input type="radio"/> No	
Comments: (Explain "Yes" Responses) <u>Diabetes</u> <u>pancreatitis</u>				Previous PPD test? <input checked="" type="radio"/> Yes <input type="radio"/> No	
VITAL SIGNS				Previous Positive Reaction? <input checked="" type="radio"/> Yes <input type="radio"/> No	
HT <u>6'1"</u> WI <u>199</u> BP <u>140/80</u>				If positive result: When _____ Where _____	
Pulse <u>70</u> Resp <u>20</u> Temp <u>98.1</u>				Chronic Cough/Blood <input checked="" type="checkbox"/>	Fever <input checked="" type="checkbox"/>
DISPOSITION				Recent Weight Loss <input checked="" type="checkbox"/>	Night Sweats <input checked="" type="checkbox"/>
Referrals _____ None				Recent Appetite Loss <input checked="" type="checkbox"/>	Fatigue <input checked="" type="checkbox"/>
_____ Emergency Room (Pre-booking injury)				MEDICATIONS	
_____ Emergency Room (Acute condition)				Current Medications:	
_____ Physician				<u>NONE</u>	
_____ Sick Call				ALLERGIES	
_____ Placement _____ Infirmary				Medication Allergies: <input checked="" type="radio"/> Yes <input type="radio"/> No	
_____ Detoxification Setting				Type: _____	
_____ General Population				Other Allergies: <input checked="" type="radio"/> Yes <input type="radio"/> No	
_____ Other				Type: _____	

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals. I understand that any medications not picked up within 30 days of release will be destroyed.

SCREENED BY: Deeksu Fried

Inmate Signature: Marvin Nation

DATE: 3-1-01 TIME: 1:45P

REVIEWED BY: _____ DATE: _____ TIME: _____

**CORRECTIONAL MEDICAL SERVICE
MEDICAL HISTORY AND SCREENING**

E-63

CCR

INSTITUTION

NATION MARVIN

INMATE NAME: <i>NATION MARVIN</i>		ID# <i>141669</i>	RACE: <i>W</i>	DOB: <i>[REDACTED]</i>
INMATE QUESTIONNAIRE			CURRENT MEDICAL CONDITIONS (circle terms that apply)	
(circle one)				
1. Do you have a medical problem such as bleeding or injuries that requires immediate medical attention?	Yes	<input checked="" type="radio"/> No	Unconscious	Skin Infection
2. Have you fainted or had a head injury within past six months?	Yes	<input checked="" type="radio"/> No	Disoriented	Restricted Mobility
3. Have you been seen by a doctor in the past six months?	<input checked="" type="radio"/> Yes	No	Intoxicated	Skin Rash
4. Do you wear glasses or contact lenses?	Yes	<input checked="" type="radio"/> No	Lesions	Jaundice
5. Do you have prosthesis, splint, crutches, cast or brace that you need while here?	Yes	<input checked="" type="radio"/> No	Obvious Pain	Needle Marks
6. Do you drink wine, beer or whiskey? How often? <i>socially</i> How much? <i>1 or 2</i> Last time? <i>2 months ago</i>	<input checked="" type="radio"/> Yes	No	Bruises	Swollen Glands
7. Have you had seizures or blackouts when you stop drinking?	Yes	<input checked="" type="radio"/> No	Fever	Active Cough
8. Do you use drugs? Type _____ How often _____ Last time _____	Yes	<input checked="" type="radio"/> No	Nausea	Vaginal/Penile Discharge
9. Have you had withdrawal problems when you stop taking drugs?	Yes	<input checked="" type="radio"/> No	Uses Tobacco	Dental Problems
10. Are you currently detoxing? If yes, from what substance?	Yes	<input checked="" type="radio"/> No	MEDICAL HISTORY (circle terms that apply)	
11. Do you have any medical problems we should know about?	<input checked="" type="radio"/> Yes	No	Arthritis	Frequent Diarrhea
12. Have you been in this facility before?	<input checked="" type="radio"/> Yes	No	Diabetes	Genital Sores
			Seizure Disorder	V.D.
			Asthma	Hepatitis
			Special Diet	HIV+
			Heart Condition	Tuberculosis
			Hypertension	Persistent Sore Throat
			Stomach Ulcer	Dental Problems
			Cancer	Surgeries <i>ABDOMINAL</i>
			Sickle Cell Anemia	Chest Pain
			Emphysema	Jaundice
MENTAL HEALTH			TB HISTORY	
13. Have you ever been hospitalized or treated for psychiatric problem?	Yes	<input checked="" type="radio"/> No	Ever treated with TB Drugs?	Yes <input checked="" type="radio"/> No
14. Have you ever considered or attempted suicide?	Yes	<input checked="" type="radio"/> No	Previous PPD test?	Yes <input checked="" type="radio"/> No
15. Are you feeling depressed or extremely sad?	Yes	<input checked="" type="radio"/> No	When <i>1991</i>	Previous Positive Reaction? Yes <input checked="" type="radio"/> No
16. Do you want to hurt yourself or someone else?	Yes	<input checked="" type="radio"/> No	Where <i>CCR</i>	
17. Are you hearing voices? If yes, what are they saying?	Yes	<input checked="" type="radio"/> No	Chronic Cough/Blood	Fever
			Recent Weight Loss	Night Sweats
			Recent Appetite Loss	Fatigue
FEMALE INMATES ONLY			MEDICATIONS	
18. Are you pregnant? LMP	Yes	No	Current Medications:	
19. Do you use birth control? Type <i>1st 6/6</i>	Yes	No	<i>none</i>	
20. Have you recently had a baby, miscarriage or abortion?	Yes	No		
COMMENTS: (Explain "Yes" Responses) <i>Pancreatitis</i>				
VITAL SIGNS				
HT <i>6'10"</i> WT <i>166</i> BP <i>120/70</i>				
Pulse _____ Resp _____ Temp _____				
DISPOSITION			ALLERGIES	
Referrals <input checked="" type="checkbox"/> None	Placement		Medication Allergies: Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Emergency Room (Pre-booking injury)	<input type="checkbox"/> Infirmary		Type: _____	
<input type="checkbox"/> Emergency Room (Acute Condition)	<input type="checkbox"/> Detoxification		Other Allergies: Yes <input checked="" type="radio"/> No	
<input type="checkbox"/> Physician	<input type="checkbox"/> Setting		Type: _____	
<input type="checkbox"/> Sick Call	<input type="checkbox"/> Gen Population			
	<input type="checkbox"/> Other			

I acknowledge that I have answered all questions truthfully and have been told the way to obtain health services and consent to routine care provided by facility healthcare professionals. I understand that any medications not picked up within 30 days of release will be destroyed.

Inmate Signature: *Nation Marvin*

Screened by: *M. Miller*

Date: *14/669*

Time: *11:00 AM*

Reviewed by: _____

Date: _____

Time: _____

ALABAMA DEPARTMENT OF CORRECTIONS
MENTAL HEALTH SERVICES
RECEPTION MENTAL HEALTH SCREENING

Institution: Kilby Date/Time Inmate Received: _____
 Date/Time of Screening: 4/12/02 Signature /Title of Screener: Viola Jones, LPA

MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ADOC

- ☐ Yes ☒ No Psychotropic Medication: _____
☐ Yes ☒ No Medication turned over to a DOC upon arrival? _____
☐ Yes ☒ No Mental Health follow – up in last 90 days: _____
☐ Yes ☒ No Suicide/self harm attempts in last 90 days: _____

MENTAL HEALTH HISTORY Does inmate report a history of the following (if yes, provide details):

- ☐ Yes ☒ No Outpatient treatment: _____
☐ Yes ☒ No Inpatient treatment: _____
☐ Yes ☒ No Psychotropic Medication: _____
☐ Yes ☒ No Suicidal Attempts: _____
☐ Yes ☒ No Suicidal Thoughts: _____
☐ Yes ☒ No Head injury: _____
☐ Yes ☒ No Seizures: _____
☒ Yes ☐ No Violent Behavior: Robbery
☒ Yes ☐ No Substance Abuse: MS, ALc
☐ Yes ☒ No Substance Abuse Treatment: _____
☐ Yes ☒ No Special Education classes: _____

INMATE SELF-REPORT OF CURRENT STATUS “I hate it”

- ☐ Yes ☒ No First incarceration (reaction): _____
☒ Yes ☐ No Reports family support: _____
☐ Yes ☒ No Reports serious depression/remorse: _____
☐ Yes ☒ No Thinking about suicide: _____
☐ Yes ☒ No Has plan for suicide: _____
☐ Yes ☒ No Possible to implement plan: _____
☐ Yes ☒ No Reports hallucinations: _____

BEHAVIORAL OBSERVATIONS

- ☐ Poor eye contact ☐ Poor hygiene ☐ Unable to pay attention ☐ Unresponsive
☐ Disorientated ☐ Overly anxious ☐ Unable to follow directions ☒ Unable to read
☐ Crying ☐ Memory deficits ☐ Signs of self-mutilation ☐ Afraid
☐ Illogical speech content ☐ Appears to be hearing voices of seeing things ☐ Paranoid
☐ Hostile ☐ Other unusual behavior: _____

DISPOSITION PLACEMENT RECOMMENDATION (Based on reception mental health screening)

- ☐ Routine housing and mental health follow-up ☐ Emergency mental health referral
☐ Priority mental health follow-up but not emergency ☐ Safe cell recommended
☐ Current Psychotropic meds verified/interim supply ordered ☐ Parole violator interim assessment referral

Inmate Name: <u>Nation, Marvin</u>	AIS#: <u>141669</u>
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ALABAMA DEPARTMENT OF CORRECTIONS
INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child

Mental health and medical staff will have access your mental health records when completing their duties
The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records

This information on this form has been explained to me and I have received a copy of the information for my future reference.

Marvin Nation
Inmate Signature

141669
AIS #

4-12-02
Date Signed

Nation, Marvin

CORRECTIONAL MEDICAL SERVICES INTAKE MENTAL HEALTH SCREENING

INMATE NAME: <u>Nation, Marvin</u>	ID #: <u>141669</u>	RACE: <u>W</u>	D.O.B.: <u>[REDACTED]</u>
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SUICIDE POTENTIAL SCREENING		(circle)	PSYCHIATRIC SCREENING		(circle)
1. Arresting or transporting officer believes subject may be suicide risk	Yes	<u>No</u>	1. History of psychotropic medication? Type: Current Dosage: Source:	Yes	<u>No</u>
2. Lacks close family/friends in community	Yes	<u>No</u>	2. History of psychiatric hospitalization? When: Where:	Yes	<u>No</u>
3. Experienced a significant loss within last 6 months (loss of job, relationship, death of close family member)	Yes	<u>No</u>	3. History of outpatient mental health treatment? When: Where:	Yes	<u>No</u>
4. Worried about major problems other than legal situation (terminal illness)	Yes	<u>No</u>	4. History of violent behavior? When: Where:	Yes	<u>No</u>
5. Family member or significant other has attempted or committed suicide (spouse, parent, sibling, close friend, lover)	Yes	<u>No</u>	BEHAVIORAL OBSERVATIONS Difficulties observed in following area: (circle)		
6. Has psychiatric history (psychotropic medication or treatment)	Yes	<u>No</u>	Eye Contact	Terrified/crying	
7. Holds position of respect in community (i.e., professional, public official) and/or alleged crime is shocking in nature Expresses feelings of embarrassment / shame	Yes	<u>No</u>	Appearance	Orientation	
8. Expresses thoughts about killing self	Yes	<u>No</u>	Activity	Concentration	
9. Has a suicide plan and/or suicide instrument in possession	Yes	<u>No</u>	Mood	Speech	
10. Has previous suicide attempt (Check wrists & note method)	Yes	<u>No</u>	Affect	Delusional	
11. Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness)	Yes	<u>No</u>	Memory	Hallucinations	
12. Shows signs of depression (crying, emotional flatness)	Yes	<u>No</u>	Intellectual Functioning	Psychotic Symptoms	
13. Appears overly anxious, afraid or angry	Yes	<u>No</u>	COMMENTS: <u>- Violated parole by driving without license in NC, this is 2nd time. Original conviction in 1984 for receiving stolen property.</u>		
14. Appears to feel unusually embarrassed or ashamed	Yes	<u>No</u>			
15. Is acting and/or talking in a strange manner. (Cannot focus attention; hearing or seeing things not there)	Yes	<u>No</u>			
16. Is apparently under the influence of alcohol or drugs	Yes	<u>No</u>			
17. If YES to #16, is individual incoherent or showing signs of withdrawal or mental illness <u>NA</u>	Yes	<u>No</u>			
TOTAL YES'S = <u>0</u> If there are any circles in shaded areas, or total of Yes's is 8 or more, alert Shift Commander and refer for Mental Health Evaluation.					
SUMMARY			DISPOSITION		
<input type="checkbox"/> No mental health problems <input type="checkbox"/> Mental health problems requiring routine follow-up <input type="checkbox"/> Chronic mental health problem <input type="checkbox"/> Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other <input type="checkbox"/> Acute mental health problem <input type="checkbox"/> Psychosis <input type="checkbox"/> Suicidal <input type="checkbox"/> Other <input type="checkbox"/> Potential withdrawal from substance abuse			<input type="checkbox"/> Approved for General Population: <input type="checkbox"/> No Mental Health Referral <input type="checkbox"/> Approved for General Population: <input type="checkbox"/> Routine Mental Health Referral <input type="checkbox"/> Special Housing; Mental Health Referral ASAP <input type="checkbox"/> Suicide Precaution Procedures: <input type="checkbox"/> Mental Health Referral ASAP <input type="checkbox"/> Psychiatric Referral <input type="checkbox"/> Medical Monitoring for Potential Withdrawal		

SCREENED BY: <u>G. Rankin, Psy. D.</u>	DATE: <u>3/14/01</u>	TIME: <u>4:45 p.m.</u>
REVIEWED BY: _____	ID #: _____	DATE: _____ TIME: _____

CORRECTIONAL MEDICAL SERVICES INTAKE MENTAL HEALTH SCREENING

INMATE NAME: <u>NATION MARVIN</u>		ID #: <u>141669</u>	RACE: <u>W/M</u>	D.O.B.: <u>[REDACTED]</u>
-----------------------------------	--	---------------------	------------------	---------------------------

SUICIDE POTENTIAL SCREENING (circle)		PSYCHIATRIC SCREENING (circle)		
1 Arresting or transporting officer believes subject may be suicide risk	Yes	<input checked="" type="radio"/> No	1 History of psychotropic medication? Yes <input checked="" type="radio"/> No Type: Current Dosage: Source:	
2 Lacks close family/friends in community	Yes	<input checked="" type="radio"/> No	2 History of psychiatric hospitalization? Yes <input checked="" type="radio"/> No When: Where:	
3 Experienced a significant loss within last 6 months (loss of job, relationship, death of close family member)	Yes	<input checked="" type="radio"/> No	3 History of outpatient mental health treatment? Yes <input checked="" type="radio"/> No When: Where:	
4 Worried about major problems other than legal situation (terminal illness)	Yes	<input checked="" type="radio"/> No	4 History of violent behavior? Yes <input checked="" type="radio"/> No When: Where:	
5 Family member or significant other has attempted or committed suicide (spouse parent sibling, close friend lover)	Yes	<input checked="" type="radio"/> No	BEHAVIORAL OBSERVATIONS Difficulties observed in following area: (circle)	
6 Has psychiatric history (psychotropic medication or treatment)	Yes	<input checked="" type="radio"/> No	Eye Contact	Terrified/crying
7 Holds position of respect in community (i.e., professional public official) and/or alleged crime is shocking in nature Expresses feelings of embarrassment / shame.	Yes	<input checked="" type="radio"/> No	Appearance	Orientation
8 Expresses thoughts about killing self	Yes	<input checked="" type="radio"/> No	Activity <u>OK</u>	Concentration <u>OK</u>
9 Has a suicide plan and/or suicide instrument in possession	Yes	<input checked="" type="radio"/> No	Mood	Speech
10 Has previous suicide attempt (Check wrists & note method)	Yes	<input checked="" type="radio"/> No	Affect	Delusional
11 Expresses feelings there is nothing to look forward to in the future (feelings of helplessness and hopelessness)	Yes	<input checked="" type="radio"/> No	Memory	Hallucinations
12 Shows signs of depression (crying emotional flatness)	Yes	<input checked="" type="radio"/> No	Intellectual Functioning	Psychotic Symptoms
13 Appears overly anxious, afraid or angry	Yes	<input checked="" type="radio"/> No	COMMENTS:	
14 Appears to feel unusually embarrassed or ashamed	Yes	<input checked="" type="radio"/> No		
15 Is acting and/or talking in a strange manner. (Cannot focus attention; hearing or seeing things not there)	Yes	<input checked="" type="radio"/> No		
16 Is apparently under the influence of alcohol or drugs.	Yes	<input checked="" type="radio"/> No		
17 If YES to #16 is individual incoherent or showing signs of withdrawal or mental illness	Yes	No		
TOTAL YES S = If there are any circles in shaded areas, or total of Yes s is 8 or more, alert Shift Commander and refer for Mental Health Evaluation.				
SUMMARY				
<input checked="" type="checkbox"/> No mental health problems <input type="checkbox"/> Mental health problems requiring routine follow-up <input type="checkbox"/> Chronic mental health problem <input type="checkbox"/> Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other <input type="checkbox"/> Acute mental health problem <input type="checkbox"/> Psychosis <input type="checkbox"/> Suicidal <input type="checkbox"/> Other <input type="checkbox"/> Potential withdrawal from substance abuse				
DISPOSITION				
<input checked="" type="checkbox"/> Approved for General Population: No Mental Health Referral <input type="checkbox"/> Approved for General Population: Routine Mental Health Referral <input type="checkbox"/> Special Housing: Mental Health Referral ASAP <input type="checkbox"/> Suicide Precaution Procedures: Mental Health Referral ASAP <input type="checkbox"/> Psychiatric Referral <input type="checkbox"/> Medical Monitoring for Potential Withdrawal				

SCREENED BY: <u>JOHN MEETAN</u>	DATE: <u>8/24/9</u>	TIME: _____
REVIEWED BY: _____	ID #: _____	DATE: _____ TIME: _____

Treatment Continued:

Drsg A to lt leg qd x 7 days

Date	Date	Date	Date	Date	Date	Date
9/23	9/24	9/25	9/26	9/27	9/28	9/29
				IN DORS	IN DORS	
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Patient Name/Number	Allergies:	Housing Unit:
Nation, Marvin		Elmore

FROM : 10/04/2004 11:00 FAX: 3345858158 FAX NO. : REGIONAL OFFICE ADMIN **Elmore** Oct. 04 2004 01:13PM P29 0005 0001/004

UTILIZATION MANAGEMENT REFERRAL REVIEW FORM

Please write this form with the Authorization Letter to the service provider at the time of the appointment.

DEMOGRAPHICS	
SUB Name & Number City/State ZIP/Phone 334-245-6705 Bldg/Fax 334-245-0125 With new card charges? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Responsible party: <input type="checkbox"/> PMS <input type="checkbox"/> Auto Inc. <input type="checkbox"/> Other, be specific (Excludes Medicare and Medicaid)	Patient Name (Last, First) Robert, Marvin Age: 62 Yrs Member ID 141669 SSN Number Date of Birth (mm/dd/yyyy) 9/29/04 Date of Birth (mm/dd/yyyy) 4/12/02 Potentially Release Date (mm/dd/yyyy) 10/27/09

CLINICAL DATA	
Referring Provider: <input checked="" type="checkbox"/> Physician <input type="checkbox"/> NP, PA <input type="checkbox"/> Dental Dr. Keen Facility Medical Director Signature and Date: Michael J. Keen MD <input type="checkbox"/> Service member check for "approval via protocol" Please check mark (✓) by the Service Type requested (one only) and complete additional applicable fields. <input checked="" type="checkbox"/> Office Visit (OV) <input type="checkbox"/> X-ray (X) <input type="checkbox"/> Scheduled Admission (SA) <input type="checkbox"/> Outpatient Surgery (OS) <input type="checkbox"/> Diagnostics (DA) <input type="checkbox"/> Physical <input type="checkbox"/> Urgent Estimated Date of Service (mm/dd/yyyy) (This starts the approval window for the "Open Authorization period") Multiple Visits/Treatments: <input type="checkbox"/> Radiation therapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other Number of Visits/Treatments: Specialist referred to: Oral Surgeon Type of Consultation, Treatment, Procedure or Surgery: Post-op F14 x 1 week You must include copies of pertinent reports such as lab results, x-ray interpretations and specialty consult reports with this form. <input type="checkbox"/> Patient's documents have been attached and filed.	History of illness/injury/symptoms with Date of Onset: SIP @ ORIF Results of a complete directed physical examination: Previous treatment and response (including medications): For security and safety, please do not inform patient of possible follow-up appointments.

UNDETERMINATION: <input type="checkbox"/> Alternative Treatment Plan (explain here) <input type="checkbox"/> More information requested. (See Attached) <input type="checkbox"/> Reauthorized with requested information.	Service Recommended and Authorized Date recommended: Regional Medical Director Signature, printed name and title: Dr. J. Keen MD Do not write below this line. For Case Manager and Corporate Data Entry only. Case Type: F14 99211 14257495
---	---

PRISON
HEALTH
SERVICES
INCORPORATED

EC *MOU* *RTE*
~~*Elmore*~~

Special Diet Request

Inmate's Name: Nation Marvin W/141669 Date: 9/23/04Housing Location: \$ ElmoreType of Diet: liquid dietStart Date: 9/23/04 Stop Date: 10/23/04

Special Instructions (if needed):

NPD after midnight 9/23/04Date Requested: 9/22/04 Signature: L. Hassler, CRNP / J. G. [unclear]



SPECIAL NEEDS COMMUNICATION FORM

Date: 10/21/04

To: Edmore

From: SHen

Inmate Name: Nation, Marvin ID#: 141669

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

Soft diet x 6 wks

Date: 10/21/04 MD Signature: Dr. Williams / Sullivan Time: 1540



PRISON
HEALTH
SERVICES
INCORPORATED

Special Diet Request

Inmate's Name: Nation Marnon Date: 10/6/04

Housing Location: WW#135

Type of Diet: Puree → soft mechanical

Start Date: 10/6/04 Stop Date: _____

Special Instructions (if needed): Puree until notified > soft mech

Date Requested: 10/6/04 Signature: Dr. Robbins / A. Miller Jr

10130 (10/89)

(White - Kitchen Copy, Yellow - Patient File Copy)

4. May have extra _____
5. Other _____

Comments:

- ① Peanut Butter Sandwich at Bedtime x 3 wks
- ② Soft Diet until further notice

Date: 10/7/04 MD Signature: _____ Time: 3:15 pm



SPECIAL NEEDS COMMUNICATION FORM

Date: 10-7-04To: Elmore CCFrom: SHC UInmate Name: NATION, MARVIN ID#: 141669

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

- ① NO Lifting greater than 10lbs x 4 weeks
- ② Light Duty x 4 weeks
- ③ No prolong Standing x 30 mins x 4 weeks
- ④ Bottom Back profile x 4 weeks

Date: 10/7/04 MD Signature: [Signature] Time: 3:15 pm



PRISON
HEALTH
SERVICES
INCORPORATED

EMERGENCY

ADMISSION DATE 3/30/04		TIME 9:28 AM	ORIGINATING FACILITY Elmore <input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT																			
ALLERGIES NKA			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA																					
VITAL SIGNS: TEMP 97.9		ORAL RECTAL	RESP 20	PULSE 76	B/P 128/82	RECHECK IF SYSTOLIC <100 > 50 128/196																		
NATURE OF INJURY OR ILLNESS S - "I have a cft in (R) nose". x 5 days			<table border="1"> <tr> <td>ABRASION ///</td> <td>CONTUSION #</td> <td>BURN xx xx</td> <td>FRACTURE Z Z</td> <td>LACERATION / SUTURES</td> </tr> </table>				ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES													
ABRASION ///	CONTUSION #	BURN xx xx	FRACTURE Z Z	LACERATION / SUTURES																				
PHYSICAL EXAMINATION O - Was red and swollen area noted to (R) nose. No drainage noted. Rt inner nose & exudate. Biopsy A - Cyst P - M.D. @ Elmore																								
			<table border="1"> <tr> <td>ORDERS / MEDICATIONS / IV FLUIDS</td> <td>TIME</td> <td>BY</td> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table>				ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY															
ORDERS / MEDICATIONS / IV FLUIDS	TIME	BY																						
DIAGNOSIS Body chart																								
INSTRUCTIONS TO PATIENT RT C as needed																								
DISCHARGE DATE 3/30/04		TIME AM PM	RELEASE / TRANSFERRED TO DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input checked="" type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL																			
NURSE'S SIGNATURE Bernell		DATE	PHYSICIAN'S SIGNATURE [Signature]		DATE 3/30/04																			
INMATE NAME (LAST, FIRST MIDDLE) Nation, Marvin			DOC# 141669	DQB [Redacted]	R/S w/m	FAC. Elm																		



EMERGENCY

ADMISSION DATE 9/22/04		TIME 4:30 AM PM	ORIGINATING FACILITY Elmore		<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES NKDA			CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input checked="" type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 98		ORAL RECTAL	RESP 20	PULSE 76	B/P 118/80	RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS S - Body Chest Per DOC			ABRASION /// CONTUSION # BURN xx FRACTURE Z LACERATION / SUTURES			
PHYSICAL EXAMINATION D - Bruise TO (L) Orbit of eye - POSS blood in sclera (L) eye Swelling (L) jaw Disg > (L) VEXT. - Sm Loc x2 on (L) lower aspect of (L) V leg A - Alt. in 1 kind of integument, ALT h's Compst						
P - Adm H PT TO mov until to Surg. Disg 1's @ 9/22 (L) leg x 7 days by Diet full T Surg med's order see MAR			ORDERS / MEDICATIONS / IV FLUIDS TIME BY			
DIAGNOSIS						
INSTRUCTIONS TO PATIENT						
DISCHARGE DATE 9/24/04		TIME 1:00 AM PM	RELEASE / TRANSFERRED TO DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE [Signature]		DATE 9/24/04	PHYSICIAN'S SIGNATURE [Signature]		CONSULTATION	
INMATE NAME (LAST, FIRST, MIDDLE) NATION, Marvin			DOC# 141669	DOB [REDACTED]	R/S Wm	FAC Elmore



EMERGENCY

ADMISSION DATE 9/21/04	TIME 2:25 AM PM	ORIGINATING FACILITY ECC	<input type="checkbox"/> SICK CALL <input type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES NKA		CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 98.1	ORAL RECTAL	RESP 20	PULSE 68	B/P 90/72 RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS S - Bodychart per DOC request removed on Road Squad		ABRASION ///	CONTUSION #	BURN <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> FRACTURE <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> LACERATION / SUTURES
PHYSICAL EXAMINATION O - Ambulated to hallway slight limp - bandage to right extremity bright red blood noted - reinforced clean 4x4's and secured to right clay and mandible/marullary edematous to bruising noted Alert and conversing to nurse/officer Acute distress noted A - Alliteration in comfort P - MD to review		<p>PROFILE RIGHT OR LEFT</p> <p>RIGHT OR LEFT</p>		
		ORDERS / MEDICATIONS / IV FLUIDS TIME BY		
DIAGNOSIS				
INSTRUCTIONS TO PATIENT				
DISCHARGE DATE 9/21/04	TIME 2:35 AM PM	RELEASE / TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input checked="" type="checkbox"/> AMBULANCE <input type="checkbox"/>	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE Michelle Ford	DATE 9/21/04	PHYSICIAN'S SIGNATURE Russell Cap	DATE 9-22-04	CONSULTATION
INMATE NAME (LAST FIRST MIDDLE) Nation Marvin		DOC# 1241669	DOB [REDACTED]	R/S w/m FAC

Treatment Continued:

Warm ES soak Rt mare T qd x30kyp

Date	Date	Date	Date	Date	Date	Date
3-30-04	3-31-04	4-1-04				
Don't per se @ camp m3						
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date
Initials	Initials	Initials	Initials	Initials	Initials	Initials

Date	Date	Date	Date	Date	Date	Date

Comments:

Patient Name/Number	Allergies:	Housing Unit:
141669 Nation, Marvin	NKSA	Elmore

Prison Health Services Informed Consent Flu Vaccine

MARVIN NATION
Name of Inmate

12/5/03
Date

141669 [REDACTED]
Inmate AIS# & Date of Birth

I hereby authorize Prison Health Services employees and agents to give me the flu vaccine.

I understand the above procedure is necessary to treat my condition and the procedure has been explained to me. I also understand the nature of the risks associated with this procedure.

I acknowledge no guarantees have been made as to the results of this procedure.

I sign this willingly and voluntarily in full understanding of the above, and I release Prison Health Services, and its employees and agents from any and all liability which may arise from this action.

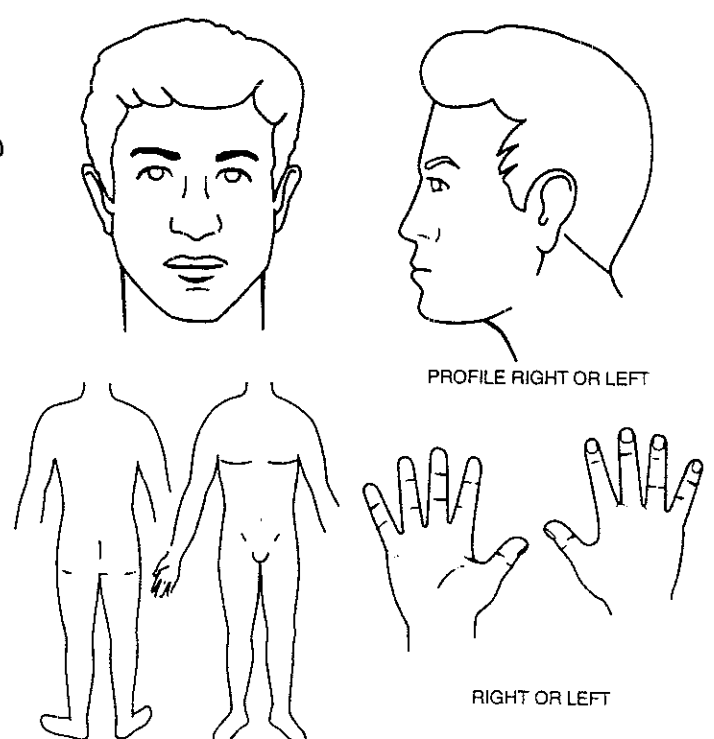
Marvin Nation
Inmates Signature

Witness

12/5/03 - 10pm
Date and Time

Witness

EMERGENCY

ADMISSION DATE 11/23/03		TIME 9:00 AM	ORIGINATING FACILITY LCF		<input type="checkbox"/> SICK CALL <input checked="" type="checkbox"/> EMERGENCY <input type="checkbox"/> OUTPATIENT	
ALLERGIES none			CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 99.3		ORAL RECTAL	RESP 22	PULSE 104	B/P /	RECHECK IF SYSTOLIC <100> 50 /
NATURE OF INJURY OR ILLNESS (S) I have a cold, feel real bad. Chest feels hot. (C) Congested, tired-looking Temp. Yellow/green mucus nose red. Slight hives mid-sternal. Sweaty, hot. (D) Cold / bronchitis (P) Keflex 500 TID Tylenol 4 B/D Cough tabs 4 TID Tylenol 4 TID (E) Come to jail call TID drink lots of H ₂ O & juice eat and rest.			ABRASION /// CONTUSION # BURN xx xx FRACTURE Z Z LACERATION / SUTURES			
			 <p>PROFILE RIGHT OR LEFT</p> <p>RIGHT OR LEFT</p>			
PHYSICAL EXAMINATION			ORDERS / MEDICATIONS / IV FLUIDS			
			TIME			
			BY			
DIAGNOSIS See "A"						
INSTRUCTIONS TO PATIENT See "P"						
DISCHARGE DATE 11/23/03		TIME 9:30 AM	RELEASE / TRANSFERRED TO SBOC		CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE [Signature]		DATE 11/23/03	PHYSICIAN'S SIGNATURE [Signature]		DATE 11/24/03	
INMATE NAME (LAST, FIRST MIDDLE) Dutton, Marvin			DOC# 141669	DOB [REDACTED]	R/S w/m	FAC LCF

DOC N610
09/87

ALABAMA DEPARTMENT OF CORRECTIONS

RECEIVING SCREENING FORM

INMATES NAME: NATION, MARVIN DATE: 8-26-02 TIME: 11:00pmDOB: X [REDACTED] OFFICER: CO. [REDACTED] INSTITUTION: LCFBOOKING OFFICERS VISUAL OPINIONYes No

1. Is the Inmate Conscious ? Yes —
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services ? — X
3. Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care ? — X
4. Any obvious fever, swollen lymphnodes, jaundice, or other evidence of infection which might spread through the institution ? — X
5. Is the skin in poor condition or show signs of vermin or rashes ? — X
6. Does the inmate appear to be under the influence of Alcohol, or Drugs ? — X
7. Are there any visible signs of Alcohol or Drug withdrawal ? (Extreme perspiration, shakes, nausea, pinpoint pupils etc) — X
8. Is the inmate making any verbal threats to staff or other inmates ? — X
9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available ? — X
10. Does the inmate have any obvious physical handicaps ? — X

IF THE ANSWER IS YES TO ANY QUESTIONS FROM 2 to 10 ABOVE - SPECIFY WHY IN SECTION BELOW

11. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder? — X
12. Are you on any special diet prescribed by a physician ? (if yes - what type ?) — X
13. Do you have a history of venereal disease or abnormal discharge ? — X
14. Have you recently been hospitalized or recently seen a medical or psychiatric doctor for any illness ? — X
15. Have you ever attempted suicide ? (If yes - When ? _____ How ? _____) — X
16. Do you want to do any harm to yourself now ? — X

	<u>Yes</u>	<u>No</u>	<u>No Response</u>
17. Do you want to talk to a mental health counselor ?	_____	<u>X</u>	_____
18. Are you allergic to any medication ?	_____	<u>X</u>	_____
19. Have you recently fainted or had a head injury ?	_____	<u>X</u>	_____
20. Do you have epilepsy ?	_____	<u>X</u>	_____
21. Do you have a history of tuberculosis ?	_____	<u>X</u>	_____
22. Do you have diabetes ?	_____	<u>X</u>	_____
23. Do you have hepatitis ?	_____	<u>X</u>	_____
24. Do you have a painful dental problem ?	_____	<u>X</u>	_____
25. Do you have any medical problem we should know about ?	<u>X</u>	_____	_____
26. Do you have a past alcohol or drug history ?	_____	<u>X</u>	_____
What type: _____ How much used: _____			
For how long: _____			
Last time you used any: _____			

COMMENTS: (Unusual behavior etc.)

FOR THE OFFICER:

27. Was the new inmate briefed on sick/dental call procedures? yes
28. This inmate was: a. Release for normal processing yes
b. Referred to appropriate health care unit _____
c. Immediately sent to health care unit _____

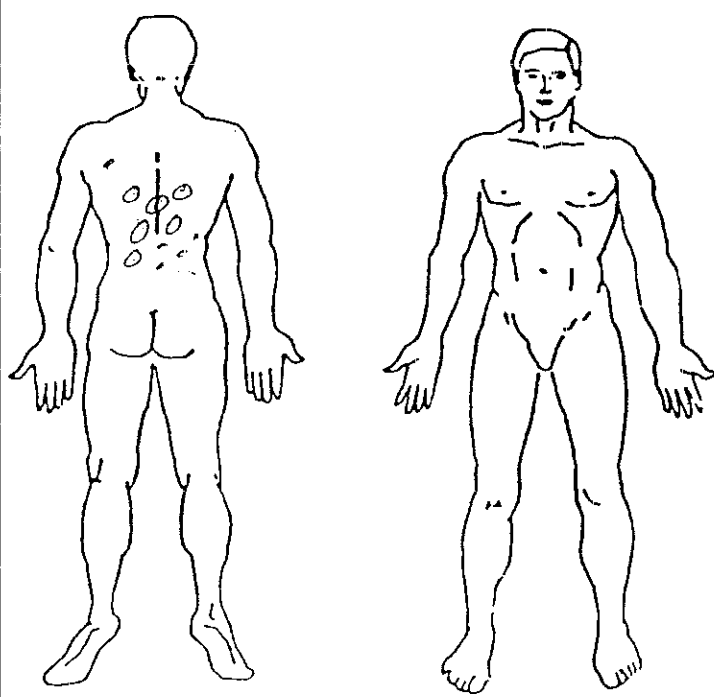
Cop. R. Bailey
Officer's Signature

NOTE: This form is completed on inter & intra system transfers at receiving and will be filed in the inmates medical jacket to comply with ACA Standards 2-4289, 2-4290 and AMA Standard 140.

Lynn Crivater
Inmate's Signature

DEPARTMENT OF CORRECT INSTITUTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE 7-5-02		TIME 3:00 AM		FACILITY STATION		<input type="checkbox"/> EMERGENCY	
				<input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input checked="" type="checkbox"/> OTHER	
ALLERGIES NKA				CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP 97.3 <input checked="" type="checkbox"/> ORAL <input type="checkbox"/> RECTAL				RESP 18		PULSE 72 B/P 110/80	
						RECHECK IF SYSTOLIC <100 > 50	
NATURE OF INJURY OR ILLNESS States rash on back. some itching noted. does not know how long. this has been on his back.				ABRASION///		CONTUSION #	
				BURN ^{xx} / _{xx}		FRACTURE ^Z / _Z	
						LACERATION/ SUTURES	
PHYSICAL EXAMINATION 6 circles on back looks like a rash - several smaller areas noted. No signs distress							
ORDERS MEDICATION etc. Antifungal cr. T.i.d. K.O.P. apply to rash. See M.D. Tuesday.							
DIAGNOSIS							
INSTRUCTIONS TO PATIENT							
RELEASE/TRANSFER DATE 7/5		TIME 102 3:15 PM		RELEASE/TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE J. Coogan RN		DATE 7-5-02		PHYSICIAN'S SIGNATURE B. Williams MD		DATE 7-7-02	
CONSULTATION							
PATIENT'S NAME (LAST FIRST MIDDLE) NATION, MARVIN				AGE 36		DATE OF BIRTH [REDACTED]	
R/S u/m		AIS # 141669					

STATION CORRECTIONAL CENTER
RECEIVING SCREENING FORM

INMATE'S NAME: MARVIN NATION AIS# 141669 DATE: 6/13/02

TIME: 10 22 AM DOB: [REDACTED] OFFICER: Julian D. Jones

Booking Officer's Visual Opinion

	YES	NO
1. Is the inmate conscious?	<u>✓</u>	
2. Does the inmate have any obvious pain or bleeding/other symptoms suggesting the need for emergency services?		<u>✓</u>
3. Are there any visible signs of trauma or illness requiring immediate emergency treatment or doctor's care?		<u>✓</u>
4. Any obvious fever, swollen lymph nodes, jaundice, or other evidence of infectious which might spread through the institution?		<u>✓</u>
5. Is the skin in poor condition or show signs of vermin or rashes?		<u>✓</u>
6. Does the inmate appear to be under the influence of alcohol or drugs?		<u>✓</u>
7. Are there any visible signs of alcohol or drug withdrawals? (extreme perspiration, shakes, nausea, pinpoint pupils, etc.)		<u>✓</u>
8. Is the inmate making any verbal threats to staff or other inmates?		<u>✓</u>
9. Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?		<u>✓</u>
0. Does the inmate have any obvious physical handicaps?		<u>✓</u>
1. Are you presently taking medication for diabetes, heart disease, seizure, arthritis, asthma, ulcers, high blood pressure or psychiatric disorder?		<u>✓</u>
2. Do you want to talk to a mental health counselor? a. Did inmate respond?	<u>✓</u>	<u>✓</u>
3. Do you have epilepsy?		<u>✓</u>
4. Do you have any medical problems we should know about?	<u>✓</u>	

Hernia

FOR THE OFFICER: (circle action)

RECEIVING SCREENING FORMINMATE'S NAME: Nation, Marvin DATE: 4/12/02 TIME: 6:55ADOB: [REDACTED] OFFICER: F. McCampbell INSTITUTION: KILBY**RECEIVING OFFICER'S VISUAL OPINION**

	YES	NO
Is the inmate conscious?	<u>✓</u>	<u> </u>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<u> </u>	<u>✓</u>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<u> </u>	<u>✓</u>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<u> </u>	<u>✓</u>
Is the skin in poor condition or show signs of vermin or rashes?	<u> </u>	<u>✓</u>
Does the inmate appear to be under the influence of alcohol, or drugs?	<u> </u>	<u>✓</u>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc)	<u> </u>	<u>✓</u>
Is the inmate making any verbal threats to staff or other inmates?	<u> </u>	<u>✓</u>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<u> </u>	<u>✓</u>
Does the inmate have any obvious physical handicaps?	<u> </u>	<u>✓</u>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was a Released for normal processing

 b. Referred to health care unit

 c. Immediately sent to the health care unit.

F. McCampbell

Officer's Signature

**NAPHCARE
ACCESS TO HEALTH CARE SERVICES @ KILBY**

All inmates have access to healthcare 24 hrs a day, 7 days a week. Treatment for routine health services complaints is processed through nurse sick call. You must complete a sick call screening form for requested health care evaluation.

Various doctor's clinics are held in the health unit Monday through Friday. If you are scheduled to be seen in a clinic you will be advised by facility daily newsletters routinely post notices of who is to report when and where for health care services. If you complete a sick-call form, please report to sick call the next business day, no later than 5:30am. Routine sick call will not be posted in the newsletter, but D.O.C. has a log of who has signed up for sick call.

If you request health services and do not show for evaluation you must sign a refusal of treatment form. If a health services appointment/clinic or treatment has been set for you and you do not show you will also have to sign a refusal of treatment form. This is to let us know you have decided you are okay and no longer need to see us.

Nurses are in house twenty-four hours a day seven days a week for routine health services and programs. Nurses are also available for emergency care. Doctor's are on call twenty-four hours a day seven days a week.

In-house medical staff reviews medical services requested over the weekend and on holidays. If your request is noted to be of a nature that will not wait until the next regularly scheduled evaluation (triage) time, you will be called to the health unit for further follow-up during this time period otherwise your request will be held until the next regularly scheduled evaluation process.

Medical emergencies such as those involving intense pain, potential life threatening situations or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest correctional officer of an emergency so prompt access to health services is provided.

Medications ordered for you by health services are to be picked up at the scheduled pill call/s established as the Doctor has ordered for you. If you fail to pick-up medications as expected you will be called for counseling. If you continue to fail to pick-up your medications you will be required to sign a refusal of treatment form.

Remember that health services are a joint effort between the patient and the health care provider. We expect you to help us help you.

Fee for services. You truly understand that no one would be denied access to health services because they are unable to pay the \$3.00 co-pay fee. You will be seen and services will be provided that are appropriate and deemed necessary. Health services staff

does not collect co-pay fees for health services nor do monies collected go to the medical provider. A nurse visit or doctor visit charge of \$3.00 is the co-pay fee. If you do not have money in your PMOD account and you are assessed a charge you will have a negative balance in your until this is cleared. A negative balance will follow you from institution to institution upon transfer. When you seek health services you will be asked to sign the co-pay signature sheet. If it is deemed that you indeed do not owe for services your account will not be charged and if a false charge is made you will be refunded. Again we do have money and are eligible to be charged the co-pay fee this will occur. If the health unit initiates the request for you to be seen there is no charge.

Educational in-services are routinely scheduled. Please attend and participate. Notice of in-services topics, dates and times will be published and posted in advance.

Complaints against health care are attempted to be resolved as soon as possible and as reasonably as possible. You may obtain a complaint form from the same place you obtain sick call request slips and you may return these where you return your sick call request slips. If your complaint is not resolved when health services person speaks with you, you may file a grievance. This form will be given to you by the health person that has attempted to resolve the complaint. A complaint form must be initiated before a grievance form can be completed.

Let your family and loved one's know health services will not disclose your medical care through conversations with them. If we are contacted you should know that we will review your health records but will have to let them know what you feel they should know about you. Understand, we will assure your family and loved one's you have health services available. We will also tell them that they must go through you or the Department of Corrections for release of information and that you must go through the appropriate procedures and access health services and also follow medical service recommendations. Be compliant with the health services ordered for you by your health providers.

If you have had health services outside the prison setting and we do not have these records you will need to sign release of records forms so we can obtain copies for placement in your institutional health record.

A physical is begun on you upon your arrival into the prison system. You will be notified yearly thereafter when your next physical is scheduled.

Mental health services dental services; medical services, chronic care clinics and many other health services are available. We wish you a healthy stay. If you need medical services we want you to understand how these services are obtained.

Certain over the counter medications are available to you through canteen purchase. Medical service is not involved in canteen operations.

We follow doctor's orders when dispensing medication-dose and time If over the counter medication is given by health services it is through the order of a doctor

Population pill call at this institution are scheduled as listed below. If you have medication ordered report to the pill call your medication is to be dispensed at

3:00AM

9:00AM

3:00PM

6:00PM

segregation lock-up pill call times are as listed below Your medication will be issued to you on medication rounds

3:00 AM

8:00 AM

2:30PM

If you have a question request an answer.


INMATE SIGNATURE/ DATE

WITNESS SIGNATURE/DATE

DEPARTMENT OF CORRECTIONS
PATIENT CONSENT TO TREATMENT FORM

NATION Marvin 36 4/15/02
Name of Patient Age Admission date/time

Name and Address of Spouse or Parent

1. I hereby authorize the Department of Corrections, its contracted employees, agents, physicians, dentists, psychiatrists and/or such assistants as may be selected by him/her to treat the condition(s) which appear indicated by the diagnostic studies already performed.
2. Should surgical or diagnostic procedure(s) become necessary, I will be informed of them with regard to alteration modes of treatment, the risks involved, and the nature of the procedure(s) to be done.
3. This in no way constitutes a warranty or guarantee that my present condition will be cured; the Department of Correction, its contracted staff and employees, will provide with the best possible care available, but no assurance of cure is to be assumed.
4. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release the Department of Correction, its directors and officers, its contracted staff employees, agents, and physicians from any and all liability which may arise from this action, whether or not foreseen at present

R.R.
Witness

Witness

X - Marvin Nation
Patient Signature
4/15/02
Date

CORRECTIONAL MEDICAL SERVICES
RELEASE OF INFORMATION AUTHORIZATION

Pineau

Nathan MARK 141669
Name of Inmate Inmate ID Number / Date of Birth
KTT Baptist Medical Center 3-5-01
Facility Releasing Information Date medical center Blvd.

I hereby give my consent to Correctional Medical Services and the above named facility to release the following information from my medical record to the facility/provider listed below:

- ☒ Records related to treatment of Prostate, P.S.
from _____ to 2000
- ☐ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care
- ☐ Admission Reports ☐ Discharge Reports ☐ Operative Summary Reports
- ☐ X-Ray Reports ☐ Special Studies Reports ☐ Laboratory Reports
- ☐ Immunization History ☐ Mental Health Records ☐ Psychiatric Summary Report
- ☐ Drug Treatment History and Counseling
- ☐ Other Records ✓

Naples Inc.
K. L. O. Y. Center
Facility/Provider to Receive Information P.O. Box 11 - Mt. Merapi 4236052

This information has been disclosed to you from records whose confidentiality is protected by State law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of person to whom it pertains.

I understand this authorization shall remain in full force and effect for the period of _____
_____ from today's date unless withdrawn in writing by me.

I sign this willingly and I release Correctional Medical Services and the facility from any liability which may result from such release of information.

Nathan Mark
Inmate Signature

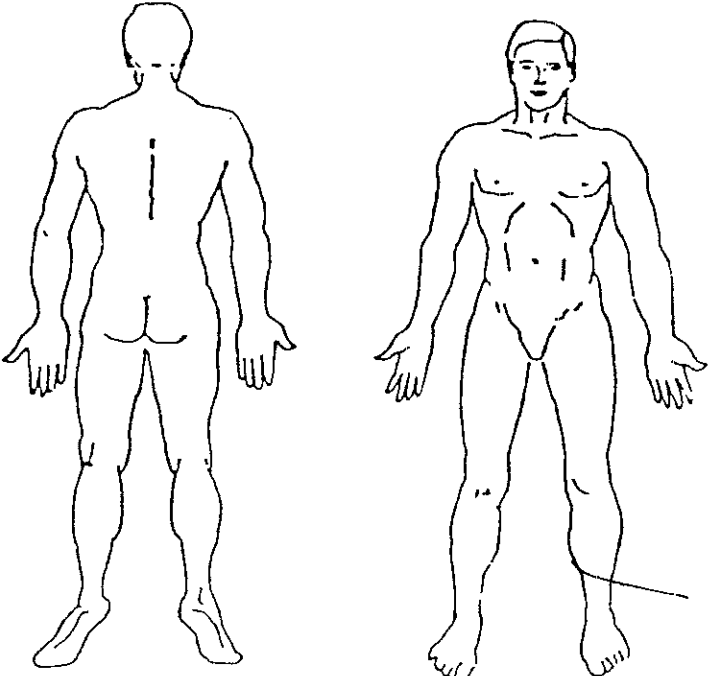
3-5-01
Date

[Signature]
Witness

[Signature]
Witness

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE 4 mar 01	TIME 1845 AM PM	FACILITY KCF <input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>	<input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER	
ALLERGIES NKDA		CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input checked="" type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 99.9 ORAL RECTAL		RESP 20	PULSE 100 B/P 144 / 80	RECHECK IF SYSTOLIC <100> 50
NATURE OF INJURY OR ILLNESS "my pancreas is burning & my back is hurting"		ABRASION///	CONTUSION #	BURN ^{xx} / _{xx}
				FRACTURE ^Z / _Z
				LACERATION/ SUTURES
PHYSICAL EXAMINATION O - Alert 34 yo male holding his abdomen & rocking. Skin & W/D color pink. States to have hx of pancreatitis. A - Alt in comfort due to abd. pain				
ORDERS MEDICATION, etc. P - per Mr. Wilson RN heat pad compressor to Abd. Sick call in the Am				
DIAGNOSIS Abd pain				
INSTRUCTIONS TO PATIENT Report to Sick call in Am				
RELEASE/TRANSFER DATE 4 1 mar 10/1850	TIME AM PM	RELEASE/TRANSFERRED TO <input type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>	CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE Buelwip	DATE 4/1/01	PHYSICIAN'S SIGNATURE [Signature]	DATE 5/10/1	CONSULTATION
PATIENT'S NAME (LAST FIRST MIDDLE) Nation, Marvin		AGE 34	DATE OF BIRTH [Redacted]	R/S 141669

CORRECTIONAL MEDICAL SERVICES
CONSENT TO TREATMENT FORM

Nation, Marvin
Name of Inmate

3-1-07
Date

141069 [REDACTED]
Inmate ID Number / Date of Birth

I hereby give my consent to Correctional Medical Services, its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician.

I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Correctional Medical Services.

I also authorize the transfer of my medical records or copies of said records to any facility to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this willingly in full understanding of the above and release Correctional Medical Services, its employees and agents from any and all liability which may arise from this action.

Marvin Nation
Inmate Signature

3-1-07
Date

Witness

[Signature]
Witness

CMS

CORRECTIONAL MEDICAL SERVICES

WHAT YOU NEED TO KNOW ABOUT TETANUS

Tetanus, sometimes called lockjaw, is a very serious disease that can occur after a cut or wound lets the germ into the body. Tetanus makes a person unable to open his or her mouth or swallow, and causes serious muscle spasms. People with tetanus usually have to stay in the hospital for along time. In the United States, tetanus kills 3 out of every 10 people who get the disease. Since 1975, only 50 to 90 cases of tetanus have been reported each year.

Tetanus vaccines cause few problems. They may cause mild fever or soreness, swelling, and redness where the shot was given. These problems usually last for 1 to 2 days.

There is a rare chance that other serious problems or even death could occur after getting Tetanus. Such problems could happen after taking any medicine or after receiving any vaccine.

I have read the above information regarding Tetanus injections and understand about possible side effects.

Marcin Natio
Inmate Signature/AIS#

Date 3-1-01

Witness Connaught

Manufacturer 471638

Lot# Prater M Bryan
Administered By

HEALTH CARE UNIT

PATIENT INFORMATION SLIP

INSTITUTION

NAME

NUMBER

R/S

Lay-in for _____ days from _____ to _____

(date)

due to _____

(date)

Instructions:

Admit to Westwood

#12 BED

Failure to follow the directions above may result in a disciplinary.

9/3/98

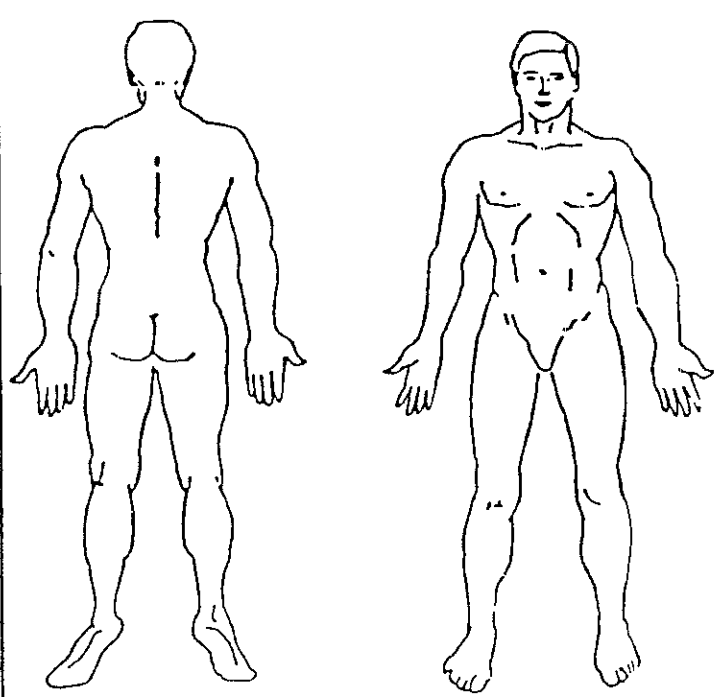
Date Issued

Signature

[Signature]

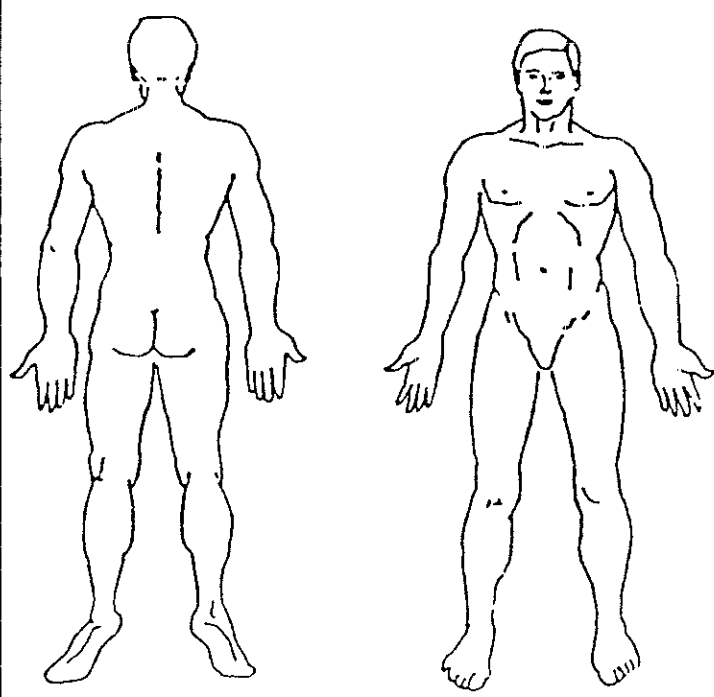
DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE <u>9/2/98</u> TIME <u>16:05</u> AM PM		FACILITY <u>KCF</u>		<input type="checkbox"/> EMERGENCY	
		<input type="checkbox"/> SIR <input type="checkbox"/> PDL <input type="checkbox"/> ESCAPEE <input type="checkbox"/>		<input type="checkbox"/> OTHER	
ALLERGIES <u>NKDA</u>		CONDITION ON ADMISSION <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA			
VITAL SIGNS: TEMP <u>97.5</u> ORAL RECTAL RESP <u>20</u> PULSE <u>84</u> B/P <u>132/84</u>		RECHECK IF SYSTOLIC <u>132</u> <100 > 50			
NATURE OF INJURY OR ILLNESS <u>My pancreas is hurting</u> <u>It hurts real bad</u> <u>Diagnosed and a V/O</u> <u>diff. L/O pain to upper</u> <u>abd, VIS WNL, PERKLA</u> <u>lung sounds clear, other</u> <u>WNL to touch BLS active</u>		ABRASION///		CONTUSION #	BURN xx xx
		FRACTURE Z Z		LACERATION/ SUTURES	
PHYSICAL EXAMINATION <u>all 4 quads, color</u> <u>of skin pale, pt raised</u> <u>no other C/O</u> <u>AD Attention to comfort,</u>					
ORDERS MEDICATION, etc <u>(V/O Per Dr. An.)</u>					
<u>P) 12 NS 150/150/hr</u>					
<u>22 NPO</u>					
<u>37 Demoral 50mg IM</u>					
DIAGNOSIS					
INSTRUCTIONS TO PATIENT					
RELEASE/TRANSFER DATE <u>9/2/98 16:55</u> AM PM		RELEASE/TRANSFERRED TO <input type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>		CONDITION ON DISCHARGE <input type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE <u>W. Pugh CM</u> DATE <u>9/3/98</u>		PHYSICIAN'S SIGNATURE <u>Heard</u> DATE <u>9/3/98</u>		CONSULTATION	
PATIENT'S NAME (LAST FIRST MIDDLE) <u>Nation, Marvin</u>		AGE <u>32</u>	DATE OF BIRTH <u>[REDACTED]</u>	R/S <u>W/R</u>	AIS # <u>141669</u>

DEPARTMENT OF CORRECTIONS

EMERGENCY/ (OTHER) TREATMENT RECORD

DATE 8/22/98	TIME 1505	FACILITY Kilby	<input type="checkbox"/> EMERGENCY <input type="checkbox"/> OTHER	
ALLERGIES NKA		CONDITION ON ADMISSION <input checked="" type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> SHOCK <input type="checkbox"/> HEMORRHAGE <input type="checkbox"/> COMA		
VITAL SIGNS: TEMP 98.6		ORAL RECTAL	RESP 20	PULSE 80 B/P 110/80
NATURE OF INJURY OR ILLNESS 'Bodychart' New inmate just arriving S- No complaints voiced.		RECHECK IF SYSTOLIC < 100 > 50		
PHYSICAL EXAMINATION O- No visible injuries or scars noted. no tattoos. A- No acute distress noted @ present time.		ABRASION///	CONTUSION #	BURN <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
		FRACTURE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	LACERATION/ SUTURES	
ORDERS MEDICATION, etc.				
P- Released to DOC				
DIAGNOSIS				
INSTRUCTIONS TO PATIENT				
RELEASE/TRANSFER DATE 8/22/98	TIME 1515	RELEASE/TRANSFERRED TO <input checked="" type="checkbox"/> DOC <input type="checkbox"/> AMBULANCE <input type="checkbox"/>	CONDITION ON DISCHARGE <input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> POOR <input type="checkbox"/> FAIR <input type="checkbox"/> CRITICAL	
NURSE'S SIGNATURE R. Burkette, LPN	DATE 8/22/98	PHYSICIAN'S SIGNATURE [Signature]	DATE 8/25/98	CONSULTATION
PATIENT'S NAME (LAST FIRST, MIDDLE) Nation, Marvin		AGE 32	DATE OF BIRTH [Redacted]	R/S W/M
				AIS # 14669

CORRECTIONAL MEDICAL SERVICES
CONSENT TO TREATMENT FORM

Martin, Marquis
Name of Inmate

8/24/08
Date

141663 [REDACTED]
Inmate ID Number / Date of Birth

I hereby give my consent to Correctional Medical Services, its employees and agents to perform any diagnostic laboratory procedures, examinations, x-rays, oral or injected medications or other procedures recommended by the physician.

I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made regarding the result of treatments or examinations performed by Correctional Medical Services.

I also authorize the transfer of my medical records or copies of said records to any facility to which I am referred for treatment or to any other correctional facility to which I am transferred.

I understand I may withdraw this consent to any specific treatment by refusing the treatment or test.

I sign this willingly in full understanding of the above and release Correctional Medical Services, its employees and agents from any and all liability which may arise from this action.

Marquis Martin
Inmate Signature

8/24/08
Date

Witness

C. Turner
Witness

RECEIVING SCREENING FORMINMATE'S NAME: Nation, Marvin DATE: 8/22/98 TIME: 2:15 PMDOB: [REDACTED] OFFICER: A. Gibson INSTITUTION: KILBY**RECEIVING OFFICER'S VISUAL OPINION**

	YES	NO
Is the inmate conscious?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the skin in poor condition or show signs of vermin or rashes?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the inmate appear to be under the influence of alcohol, or drugs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the inmate making any verbal threats to staff or other inmates?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Does the inmate have any obvious physical handicaps?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

FOR THE OFFICER

Was the new inmate oriented on sick/dental call procedures?

This inmate was ☒ a Released for normal processing

☐ b Referred to health care unit

☐ c Immediately sent to the health care unit

Anthony J. Gibson
Officer's Signature

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards



PRISON
HEALTH
SERVICES
INCORPORATED

Special Diet Request

MOU

Inmate's Name: Nation Marvin Date: 9/23/04

Housing Location: B Elmore

Type of Diet: liquid diet

Start Date: 9/23/04 Stop Date: 10/23/04

Special Instructions (if needed):

NPD aftermidnight 9/23/04

Date Requested: 9/22/04 Signature: L. Hassler, CNP / J. A. [unclear]

60130 (10/89)

(White - Kitchen Copy, Yellow - Patient File Copy)

- 4 May have extra _____ until _____
- 5 Other _____

Comments:

May transfer back to prior facility's
infirmary

Date: 9/27/04 MD Signature: DR. Robbins / L. A. [unclear] Time: 07



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/26/4

To: ADOC

From: PHS

Inmate Name: Nation, marvin ID#: 141669

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

placed on WV Hospital Bed # ~~10~~ 14

Date: 9/26/4 MD Signature: Robb Time: 12:30pm



SPECIAL NEEDS COMMUNICATION FORM

Date: 9/26/4

To: APC

From: PHS

Inmate Name: Nation, Marvin ID#: 141669

The following action is recommended for medical reasons:

1. House in _____
2. Medical Isolation _____
3. Work restrictions _____
4. May have extra _____ until _____
5. Other _____

Comments:

K.A.P. T.A.O. neospain packets + vit A+D
sent. Nasal Spray.

Date: 9/26/4 MD Signature: Rohr Time: 1230 p

HEALTH CARE UNIT
PATIENT INFORMATION SLIP

E-63

KILBY

INSTITUTION

Nation, Marvin

141669

NAME

NUMBER

R/S

Lay-in for _____ days from _____ to _____

(date)

due to

(date)

Instructions:

REPORT TO THE MENTAL HEALTH CLINIC MONDAY,

8/24/98 WITH DR. MEEHAN AT 2:00PM.

Failure to follow the directions above may result in a disciplinary.

8/24/98

Date Issued

S. Turner, Mental Health Secretary

Signature

PRISON
HEALTH
SERVICES
INCORPORATED

Date 10/05/04

		11-7		7-3		3-11				11-7		7-3		3-11	
Time															
Assessed by (initials):															
RESPIRATORY	Quality														
	Normal														
	Shallow														
	Deep														
	Labored														
	Rate - WNL														
	Slow														
	Rapid														
	Sounds - Clear														
	Abnormal														
	Cough - Productive														
	Non-Productive														
	Humidified O2 Therapy														
	L/Minute														
Incentive Spirometer															
Suctioning-Oral/NI/Trach															
TUBES AND DRAINAGE															
WOUNDS/ULCERS/DRESSINGS	Wound healing & inflammation														
	Dressing Dry & intact														
	Dressing Changed														
	Size														
	Type														
TREATMENTS	Location														
PULSE/RATE															
REFERRALS															
I.V. THERAPY	Bottle #/Rate														
NURSE S SIGNATURE:	RN 11-7					LPN 11-7					11-7				
	7-3					7-3					7-3				
	3-11					3-11					3-11				

		11-7	7-3	3-11			11-7	7-3	3-11
Time			8AM		Time			8AM	
Assessed by (Initials):			120		Assessed by (Initials):			120	
BEHAVIORMENTAL STATUS	Alert		✓		SKIN	Temperature: Warm		✓	
	Oriented x 3		✓			Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good		✓	
	Cooperative		✓			Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry		✓	
	Depressed					Moist			
						Color: WNL		✓	
SPEECH	Clear		✓		Pale				
	Slurred				Flushed				
	Rambling				Cyanotic				
	Aphasic				Jaundice				
	Inappropriate				Edema (location/amount)				
SENSATION/MOVEMENT	Moves all extremities		✓		TUBE FEEDINGS	Free of pressure/irritation			
	Weakness					Tube feeding/Type:			
	Paralysis					Bottle changed			
	Paresthesia					Tubing changed			
	CMS intact								
ACTIVITIES	Bedrest				SAFETY	Restraints: soft wrist/posey			
	Turn q 2 hours					Call light in reach			
	OOB (chair)					Bed in low position		✓	
	BRP					Siderails: up x 4		100	
	Bedside commode					Ambularm			
	Ambulate <i>self</i>		✓						
HYGIENE	Complete/Assist/Partial				OTHER	Decub. mattress/pad			
	Shower/Shampoo					TED hose: knee hi/thigh hi			
	Oral Care					Remove 30 q 8 hours			
	P M Care				NURSING ROUNDS	Checked on rounds		✓	
	Peri-Care					Respirations unchanged		✓	
	Self		✓						
Doctor's visits									

✓

Acceptable normal

X Within normal limits

INMATE NAME (LAST FIRST, MIDDLE)

Nation, Marvin

DOC#

141669

DOB

RACE/SEX

W/m

FAC

KCF



PRISON
HEALTH
SERVICES
INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date

10/04/04

		11-7		7-3		3-11				11-7		7-3		3-11		
Time								Time								
Assessed by (initials):								Assessed by (initials):								
RESPIRATORY	Quality							TUBES AND DRAINAGE								
	Normal															
	Shallow															
	Deep															
	Labored															
	Rate - WNL															
	Slow															
	Rapid															
	Sounds - Clear															
	Abnormal															
	Cough - Productive															
	Non-Productive															
	Humidified O2 Therapy															
	L/Minute															
Incentive Spirometer																
Suctioning-Oral/Ni/Trach																
ABDOMEN	Abdomen soft & nondistended							TREATMENTS								
	Abnormal															
	Bowel sounds - Active															
	Abnormal															
PULSE/RATE	Pain-Tenderness							I.V. THERAPY								
	Regular															
	Irregular															
	Strong															
	Weak															
REFERRALS	Apical															
	Radial															
	Patient Teaching															
NURSE S SIGNATURE:	RN 11-7					LPN 11-7					11-7					
	7-3					7-3					7-3					
	3-11					3-11					3-11					

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	RACE/SEX	FAC.
Nation, Marvin	141669	[REDACTED]	W/M	KCF

PRISON
HEALTH
SERVICES
INCORPORATED

Date 10/1/2019

PRISON HEALTH SERVICES INCORPORATED						Date 10/1/04	
	11-7	7-3	3-11		11-7	7-3	3-11
Time	0330	0830		Time	0330	0830	
Assessed by (initials):	MJ	RJ		Assessed by (initials):	MJ	RJ	
RESPIRATORY	Quality			TUBES AND DRAINAGE			
	Normal	✓	✓				
	Shallow						
	Deep						
	Labored						
	Rate - WNL	✓	✓				
	Slow						
	Rapid						
	Sounds - Clear	✓	✓				
	Abnormal						
	Cough - Productive						
	Non-Productive						
	Humidified O2 Therapy						
	L/Minute						
Incentive Spirometer			WOUNDS/ULCERS/DRESSINGS	Dressing Dry & Intact			
Suctioning-Oral/NI/Trach				Dressing Changed			
				Size			
				Type			
				Location			
				(D) to skin	✓		
				(E) from	✓		
ABDOMEN	Abdomen soft & nondistended	✓	✓	TREATMENTS	Janus wire I and saline rinses	✓	
	Abnormal						
	Bowel sounds - Active	✓	✓				
	Abnormal						
Pain-Tenderness							
PULSE/RATE	Regular	✓	✓	I.V. THERAPY	Bottle #/Rate		
	Irregular						
	Strong	✓	✓				
	Weak						
	Apical						
	Radial		✓				
REFERRALS	Patient Teaching						
NURSE S SIGNATURE:	RN 11-7 MJ	LPN 11-7 RJ	11-7				
	7-3	7-3	7-3				
	3-11	3-11	3-11				

11-7

7-3

3-11

11-7

7-3

3-11

Time		0330	0830		Time		0330	0830	
Assessed by (initials):		mg	g		Assessed by (initials):		mg	g	
BEHAVIORMENTAL STATUS	Alert	✓	✓		SKIN	Temperature: Warm	✓	✓	
	Oriented x 3	✓	✓			Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good	✓	✓	
	Cooperative	✓	✓			Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry	✓	✓	
	Depressed					Moist			
SPEECH	Clear	✓	✓			Color: WNL	✓	✓	
	Slurred					Pale			
	Rambling					Flushed			
	Aphasic					Cyanotic			
	Inappropriate					Jaundice			
SENSATION/MOVEMENT	Moves all extremities	✓	✓			Edema (location/amount)		✓	
	Weakness					Free of pressure/irritation			
	Paralysis					TUBE FEEDINGS	Tube feeding/Type:		✓
	Paresthesia				Bottle changed				
	CMS intact				Tubing changed				
ACTIVITIES	Bedrest				SAFETY	Restraints: soft wrist/posey			
	Turn q 2 hours		self			Call light in reach			
	OOB (chair)					Bed in low position	✓	✓	
	BRP	✓	✓			Siderails: up x 4	X2 ✓	AKD	
	Bedside commode					Ambularm			
	Ambulate	✓	✓		OTHER	Decub mattress/pad			
HYGIENE	Complete/Assist/Partial					TED hose: knee hi/high hi			
	Shower/Shampoo					Remove 30 q 8 hours			
	Oral Care				NURSING ROUNDS	Checked on rounds	✓	✓	
	P.M. Care					Respirations unchanged	✓	✓	
	Peri-Care								
ADLs/self		✓	✓		<input checked="" type="checkbox"/> Acceptable normal <input type="checkbox"/> Within normal limits				
Doctor's visits									

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

RACE/SEX

FAC

141669

[REDACTED]

w/m

KCF

Nations, Marvin



PRISON
HEALTH
SERVICES
INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date 9/30/04

11-7				7-3				3-11			
Time		0100	0700	1600	Time		0100	0700	1600		
Assessed by (initials):		Ng	Ng	Ng	Assessed by (initials):		Ng	Ng	Ng		
RESPIRATORY	Quality				TUBES AND DRAINAGE						
	Normal	✓	✓	✓							
	Shallow										
	Deep										
	Labored										
	Rate - WNL	✓	✓	✓							
	Slow										
	Rapid										
	Sounds - Clear	✓	✓	✓							
	Abnormal										
	Cough - Productive										
	Non-Productive										
	Humidified O2 Therapy										
	L/Minute										
Incentive Spirometer											
Suctioning-Oral/Ni/Trach											
ABDOMEN	Abdomen soft & nondistended	✓	✓	✓	TREATMENTS						
	Abnormal										
	Bowel sounds - Active	✓	✓	✓							
	Abnormal										
Pain-Tenderness											
PULSE/RATE	Regular	✓	✓	✓	I.V. THERAPY						
	Irregular										
	Strong	✓		✓							
	Weak										
	Apical	✓		✓							
Radial											
REFERRALS	Patient Teaching										
NURSE S SIGNATURE:		RN 11-7 <i>Ng</i>		LPN 11-7		11-7					
		7-3		7-3 <i>Ng</i>		7-3					
		3-11		3-11		3-11		<i>Ng</i>			

11-7

7-3

3-11

11-7

7-3

3-11

Time		0100	0700	1600	Time		0100	0700	1600
Assessed by (initials):		MS	ST	AL	Assessed by (initials):		MS	ST	AL
BEHAVIORAL STATUS	Alert	✓	✓	✓	SKIN	Temperature: Warm	✓	✓	✓
	Oriented x 3	✓	✓	✓		Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good	✓	✓	✓
	Cooperative	✓	✓	✓		Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry	✓	✓	✓
	Depressed					Moist			
						Color: WNL		✓	✓
SPEECH	Clear	✓	✓	✓	Pale				
	Slurred				Flushed				
	Rambling				Cyanotic				
	Aphasic				Jaundice				
	Inappropriate				Edema (location/amount)		✓	✓	
SENSATION/MOVEMENT	Moves all extremities	✓	✓	✓	bruying @ eye				
	Weakness				Free of pressure/irritation				
	Paralysis				TUBE FEEDINGS	Tube feeding/Type:			
	Paresthesia					Bottle changed			
	CMS intact					Tubing changed			
ACTIVITIES	Bedrest				SAFETY	Restraints: soft wrist/posey			
	Turn q 2 hours	✓				Call light in reach			
	OOB (chair)					Bed in low position	✓	✓	
	BRP	✓				Siderails: up x 4	✓		
	Bedside commode					Ambularm			
	Ambulate	✓	✓	✓		OTHER	Decub mattress/pad		
HYGIENE	Complete/Assist/Partial				TED hose: knee hi/high hi				
	Shower/Shampoo				Remove 30 q 8 hours				
	Oral Care				NURSING ROUNDS	Checked on rounds	✓	✓	
	P.M. Care					Respirations unchanged	✓	✓	
	Peri-Care								
	Doctor's visits	✓	✓	✓					

✓ Acceptable normal!

X Within normal limits

INMATE NAME (LAST, FIRST, MIDDLE)

Nahons, Marvin

DOC#

141669

DOB

[REDACTED]

RACE/SEX

W/m

FAC

ref



PRISON
HEALTH
SERVICES
INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date

9/29/04

		11-7		7-3		3-11				11-7		7-3		3-11	
Time		0500		900		1800		Time		0500		900		1800	
Assessed by (initials):		ms		Lo		Apo		Assessed by (initials):		ms		Lo		Apo	
RESPIRATORY	Quality							TUBES AND DRAINAGE							
	Normal	✓		✓		✓									
	Shallow														
	Deep														
	Labored														
	Rate - WNL	✓		✓		✓									
	Slow														
	Rapid														
	Sounds - Clear														
	Abnormal														
	Cough - Productive														
	Non-Productive														
	Humidified O2 Therapy														
	L/Minute														
Incentive Spirometer															
Suctioning-Oral/Ni/Trach															
ABDOMEN	Abdomen soft & nondistended	✓		✓		✓		WOUNDS/ULCERS/DRESSINGS	Dressing Dry & Intact						
	Abnormal								Dressing Changed						
	Bowel sounds - Active								Size						
	Abnormal								Type						
	Pain-Tenderness								Location ② ✓ ext. shin	✓					
PULSE/RATE	Regular	✓		✓		✓		TREATMENTS	Oral saline rinses	✓		✓			
	Irregular														
	Strong	✓		✓		✓									
	Weak														
	Apical	✓		✓		✓									
Radial	✓		✓		✓		I.V. THERAPY	Bottle #/Rate							
REFERRALS	Patient Teaching	✓		✓		✓									
NURSE S SIGNATURE:		RN 11-7 7-3 <i>Lo</i> 3-11				LPN 11-7 7-3 <i>Apo</i> 3-11				11-7 7-3 3-11					

11-7

7-3

3-11

11-7

7-3

3-11

Time		0500	0700	1800	Time		0500	0700	1800
Assessed by (initials):		NS		QD	Assessed by (initials):		NS	QD	QD
BEHAVIOR/MENTAL STATUS	Alert	✓	✓	✓	SKIN	Temperature: Warm	✓	✓	✓
	Oriented x 3	✓	✓	✓		Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good	✓	✓	✓
	Cooperative	✓	✓	✓		Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry	✓	✓	✓
	Depressed					Moist			
						Color: WNL	✓	✓	✓
SPEECH	Clear	✓	✓	✓	Pale				
	Slurred				Flushed				
	Rambling				Cyanotic				
	Aphasic				Jaundice				
	Inappropriate				Edema (location/amount)				
SENSATION/MOVEMENT	Moves all extremities	✓	✓	✓	bruising @ eye		✓	✓	
	Weakness			✓	Free of pressure/irritation				
	Paralysis				TUBE FEEDINGS	Tube feeding/Type:	1	1	1
	Paresthesia					Bottle changed			
	CMS intact					Tubing changed			
ACTIVITIES	Bedrest				SAFETY	Restraints: soft wrist/posey			
	Turn q 2 hours					Call light in reach			
	OOB (chair)					Bed in low position	✓	✓	✓
	BRP	✓				Siderails: up x 2	✓	✓	✓
	Bedside commode					Ambulacrum			
	Ambulate self	✓	✓	✓		OTHER	Decub mattress/pad	1	1
HYGIENE	Complete/Assist/Partial				TED hose: knee hi/high hi				
	Shower/Shampoo				Remove 30 q 8 hours				
	Oral Care				NURSING ROUNDS	Checked on rounds	✓	✓	✓
	P M Care					Respirations unchanged		✓	✓
	Peri-Care								
	self	✓	✓	✓					
Doctor's visits									

✓ Acceptable normal

X Within normal limits

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

RACE/SEX

FAC

Nations, Marvin

14/669

w/m

KCF



PRISON
HEALTH
SERVICES
INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date 9/28/04

		11-7		7-3		3-11				11-7		7-3		3-11			
Time		0000		0900		1700		Time		0000		0900		1700			
Assessed by (Initials):		MB		SV		DB		Assessed by (Initials):		MB		SV		DB			
RESPIRATORY	Quality							TUBES AND DRAINAGE									
	Normal	✓		✓		✓											
	Shallow																
	Deep																
	Labored																
	Rate - WNL	✓		✓		✓											
	Slow																
	Rapid																
	Sounds - Clear	✓		✓		✓											
	Abnormal																
	Cough - Productive																
	Non-Productive																
	Humidified O2 Therapy																
	L/Minute																
Incentive Spirometer																	
Suctioning-Oral/Ni/Trach																	
ABDOMEN	Abdomen soft & nondistended	✓		✓		✓		TREATMENTS									
	Abnormal																
	Bowel sounds - Active	✓		✓		✓											
	Abnormal																
Pain-Tenderness																	
PULSE/RATE	Regular	✓		✓		✓		I.V. THERAPY									
	Irregular																
	Strong	✓		✓		✓											
	Weak																
	Apical																
	Radial	✓		✓		✓											
REFERRALS	Patient Teaching																
NURSE'S SIGNATURE:		RN 11-7 MB				LPN 11-7 SV				11-7				7-3			
		7-3				3-11											
		3-11															

		11-7	7-3	3-11			11-7	7-3	3-11
Time		0000	0900	1700	Time		0000	0900	1700
Assessed by (initials):		MS	SV	PS	Assessed by (initials):		MS	SV	PS
BEHAVIORAL STATUS	Alert	✓		✓	SKIN	Temperature: Warm	✓	✓	✓
	Oriented x 3	✓		✓		Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good	✓	✓	✓
	Cooperative	✓		✓		Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry	✓	✓	✓
	Depressed					Moist			
						Color: WNL	✓	✓	✓
SPEECH	Clear	✓		✓	Pale				
	Slurred			✓	Flushed				
	Rambling				Cyanotic				
	Aphasic				Jaundice				
	Inappropriate				Edema (location/amount)				
SENSATION/MOVEMENT	Moves all extremities	✓		✓	TUBE FEEDINGS	Free of pressure/irritation			
	Weakness					Tube feeding/Type:			
	Paralysis								
	Paresthesia					Bottle changed			
	CMS intact					Tubing changed			
ACTIVITIES	Bedrest				SAFETY	Restraints: soft wrist/posey			
	Turn q 2 hours					Call light in reach			
	OOB (chair)					Bed in low position			
	BRP	✓		✓		Siderails: up x 4	✓	✓	✓
	Bedside commode					Ambularm			
	Ambulate	✓							
HYGIENE	Complete/Assist/Partial				OTHER	Decub mattress/pad			
	Shower/Shampoo					TED hose: knee hi/thigh hi			
	Oral Care					Remove 30 q 8 hours			
	P.M. Care				NURSING ROUNDS	Checked on rounds	✓	✓	✓
	Peri-Care					Respirations unchanged	✓		
	Doctor's visits	self ✓		✓					
					<input checked="" type="checkbox"/> Acceptable normal <input type="checkbox"/> Within normal limits				

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

RACE/SEX

FAC

Nelsons Marvin

141669

w/m

KOF

[illegible]

Time		11-7	7-3	3-11	Time		11-7	7-3	3-11
Assessed by (initials):		AS	Q	ah	Assessed by (initials):		AS	Q	ah
BEHAVIORMENTAL STATUS	Alert	✓	✓	✓	SKIN	Temperature: Warm	✓	✓	✓
	Oriented x 3	✓	✓	✓		Hot			
	Disoriented					Cool			
	Lethargic					Turgor: Good	✓	✓	✓
	Cooperative	✓	✓	✓		Fair			
	Combative/Uncooperative					Poor			
	Anxious					Moisture: Dry	✓	✓	✓
	Depressed					Moist			
SPEECH	Clear	✓	✓	✓		Color: WNL	✓	✓	✓
	Slurred					Pale			
	Rambling					Flushed			
	Aphasic					Cyanotic			
	Inappropriate					Jaundice			
SENSATION/MOVEMENT	Moves all extremities	✓	✓	✓		Edema (location/amount)	6		
	Weakness								
	Paralysis								
	Paresthesia								
	CMS intact				Free of pressure/irritation				
ACTIVITIES	Bedrest				TUBE FEEDINGS	Tube feeding/Type:			
	Turn q 2 hours <i>self</i>	✓		✓		<i>Special diet</i>	✓	✓	✓
	OOB (chair)					Bottle changed			
	BRP	✓		✓	Tubing changed				
	Bedside commode				SAFETY	Restraints: soft wrist/posey			
Ambulate <i>self</i>	✓	✓	✓	Call light in reach					
				Bed in low position			✓	✓	
				Siderails: up x 4			✓	✓	
HYGIENE	Complete/Assist/Partial				OTHER	Ambulacare			
	Shower/Shampoo					Decub mattress/pad		✓	✓
	Oral Care					TED hose: knee hi/high hi			
	P.M. Care				Remove 30 q 8 hours				
	Peri-Care				NURSING ROUNDS	Checked on rounds	✓	✓	✓
	<i>Self</i>	✓	✓	✓		Respirations unchanged	✓	✓	✓
	Doctor's visits								

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

RACE/SEX

FAC

Nations,

marvin

14/669

WM

KCF



PRISON
HEALTH
SERVICES
INCORPORATED

DAILY PATIENT ASSESSMENT SHEET

Date

9/26/04

		11-7	7-3	3-11			11-7	7-3	3-11
Time			1230		Time			1230	
Assessed by (initials):			H		Assessed by (initials):			H	
RESPIRATORY	Quality				TUBES AND DRAINAGE				
	Normal		✓						
	Shallow								
	Deep								
	Labored								
	Rate - WNL		✓						
	Slow								
	Rapid								
	Sounds - Clear		✓						
	Abnormal								
	Cough - Productive								
	Non-Productive								
	Humidified O2 Therapy								
	L/Minute								
	Incentive Spirometer								
Suctioning-Oral/NI/Trach									
ABDOMEN	Abdomen soft & nondistended		✓		WOUNDS/ULCERS/DRESSINGS	Dressing Dry & Intact			
	Abnormal								
	Bowel sounds - Active		✓						
	Abnormal								
	Pain-Tenderness								
PULSE/RATE	Regular		✓		TREATMENTS	Dressing Changed			
	Irregular								
	Strong								
	Weak								
	Apical								
	Radial								
REFERRALS	Patient Teaching				I.V. THERAPY	Bottle #/Rate			
NURSE'S SIGNATURE:		RN 11-7	7-3	3-11	LPN 11-7		7-3	3-11	11-7
					B. J. J. J.				

Time				Time			
Assessed by (initials):				Assessed by (initials):			
BEHAVIORAL STATUS	Alert						
	Oriented x 3						
	Disoriented						
	Lethargic						
	Cooperative						
	Combative/Uncooperative						
	Anxious						
	Depressed						
SPEECH	Clear						
	Slurred						
	Rambling						
	Aphasic						
	Inappropriate						
SENSATION/MOVEMENT	Moves all extremities						
	Weakness						
	Paralysis						
	Paresthesia						
	CMS intact						
ACTIVITIES	Bedrest						
	Turn q 2 hours						
	OOB (chair)						
	BRP						
	Bedside commode						
	Ambulate						
HYGIENE	Complete/Assist/Partial						
	Shower/Shampoo						
	Oral Care						
	P.M. Care						
	Peri-Care						
	Doctor's visits						
SKIN	Temperature: Warm						
	Hot						
	Cool						
	Turgor: Good						
	Fair						
	Poor						
	Moisture: Dry						
	Moist						
	Color: WNL						
	Pale						
TUBE FEEDINGS	Flushed						
	Cyanotic						
	Jaundice						
	Edema (location/amount)						
	Free of pressure/irritation						
SAFETY	Tube feeding/Type:						
	Bottle changed						
	Tubing changed						
	Restraints: soft wrist/posey						
	Call light in reach						
OTHER	Bed in low position						
	Siderails: up x 4						
	Ambulacard						
NURSING ROUNDS	Decub. mattress/pad						
	TED hose: knee hi/high hi						
	Remove 30 q 8 hours						
	Checked on rounds						
	Respirations unchanged						

✓ Acceptable normal

X Within normal limits

INMATE NAME (LAST, FIRST, MIDDLE)

DOC#

DOB

RACE/SEX

FAC

Nations

MARLIN

147749

[REDACTED]

W/M

KCF



INFIRMARY NURSING PROGRESS NOTES

Date/Time	
10/04/04@ 10:00	S: VOICES NO Complaints. O: AAOx3. ↑ Ambulatory on ward ad lib. Resps even & reg. Skin warm & dry. Color wmk. Some bruising remains to D eye. Wires intact to jaw. No problems @ present. A: Altered health status R/T dx. P: Continue physician orders. ————— J. D. Long
10/4/4 2130-	S: "I need my pain medicine" O: ↑ Ambulating around ward @ intervals NO distress noted. Mouth wired. Alert & oriented x3 No acute dx. Resp c ease A: Alt health status R/T dx P: Continue to monitor ————— J. D. Long
10/05/04@ 8AM	S: VOICES NO complaints. O: AAOx3 ↑ ambulatory in ward ad lib. Resps even & regular Skin warm & dry. Color wmk. Bruising noted to D eye, appears to be healing well. Wires remain intact to jaw. No problems noted. A: Altered health status R/T dx. P: Continue physician orders. ————— J. D. Long
10/5/04 1800	S: NO complaints voiced. O: Alert x 3. Respirations c ease. Ambulates about ward Mouth remains wired. NO distress noted. A: Altered health status R/T dx. P: Continue physician's orders. ————— J. D. Long



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INFIRMARY NURSING PROGRESS NOTES

Date/Time				
10/1/04 0830	<p>S/O - Resting quietly in bed & eyes closed. Respirations even + unlabored. Small amount of sneezing noted to (C)trous area, bruising noted to (C) & legs. Wound intact - M.A.E.W. - No dressings noted.</p> <p>A - Potential for altered nutritional status R/t above.</p> <p>P - Continue to monitor ^{no} administer ^{ensure} Examine as directed & medicate per MD ^{physician}.</p> <p>10/1/04 0830 "Talking to another inmate on unit."</p> <p>Jaws remain wired. Able to speak well through wired jaws. Corner of lower eyelids reddened. Purple bruise to (D)inner ankle area noted. Scrubbed over wound noted. (D) skin area. N.A.D. noted. Medicated for pain as ordered. Appetite fair. Consumes at least 80% of diet through straw. See daily W/S assessment - A.T. for altered nutritional - less than body requirements. (D) wired jaw.</p> <p>P - Continue to monitor and report any abnormality to MD SAT</p>			
INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Nations, Marvin	141669	[REDACTED]	w/r	100F



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INFIRMARY NURSING PROGRESS NOTES

Date/Time	
9/28/04 0900	<p>S- chin okay just still sore</p> <p>O- up ambulating on the ward NAD noted jaws wired together @ eye & purplish bruising noted around entire eye, resp. & ease</p> <p>A- alt. nutritional status</p> <p>P- will cont to monitor doc, PRN</p> <p>S. Vaughan LPM</p>
9/28/04 1700	<p>S- "Can I get some pain med-</p> <p>O- ↑ ambulating on ward. no distress noted @ eye bruised mouth wired. Cooperative behavior. Skin warm to touch. Resp & ease.</p> <p>A Alt Health Status R/L Dx</p> <p>P- Continue to monitor ——— P. Burnison</p>
9/29/04 0500	<p>S- Quietly lying in bed. Skin w/d. Resp. & ease. Mouth wired. @ eye & periorbital bruising noted. NAD at this time.</p> <p>A- Alt. Comfort lev. R/L Dx.</p> <p>P- Will continue monitoring it tx per M.D. orders. N. J. J.</p>
9/29/04 @ 9:00A	<p>S- "Can I get some more dental wax?"</p> <p>O: AAOX3. ↑ ambulatory in ward ad lib. Resp. even & regular. Skin warm & dry to touch. Color w/d. Sutures intact to @ brow & drainage noted. Bruising remains to @ eye area. Wires intact to jaw. No problems noted.</p> <p>A: Altered health status R/L dx.</p> <p>P. Continue physician orders. ——— R. D. Leary</p>

INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC
Nation, Marvin	14/16/04	[REDACTED]	W/LM	KCF



INFIRMARY NURSING PROGRESS NOTES

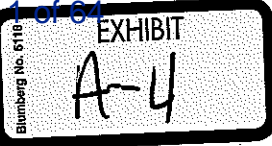
Date/Time	
9/29/04 1800	S- "Can I have something for pain?" O- Alert x 3. Respirations c ease. Ambulates about ward. No distress noted. A- Altered level of comfort R/T dx. P- Continue pain management. — A. Delaney RN
9/30/04 0100	S- "I am ok" O- Alert & oriented x 3. Respirations even & unlabored. Small amt of swelling & bruising to (L) brow area. (L) eye - noted bruising - wires to jaw intact. Mucous. No distress noted. A- Altered comfort level R/T dx. P- Continue to monitor & medicate prn — M. Bayl —
9/30/04 0700A	S- I got my way, I'm alright O- Alert & verbal, Lt. eyebrow area, stitches intact & slight swelling, redness, wires intact to oral cavity, no acute changes noted in condition. A- Potential alt. in comfort R/T dx P- Continue c. F/U Dept. and pain medication as ordered — M. Bayl —
9/30/04	S- "I'm ok right now" O- Amb. Ok ward. Smiling. Shrs M/d



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INFIRMARY NURSING PROGRESS NOTES

Date/Time											
9/26/04 12 ³⁰ _{pm}	A 38 yr old white male admitted to west ward, Sp mUA, joints wired, full liquid & pureed diet ordered. Has 2 small healing puncture wounds on Lt. leg. Left eyebrow area slightly swollen & stitches, surrounding tissue slightly red, around lower eye area black & red. Red to Lt corner of eye & C/O. Rt. hip pain, no swelling or swelling noted. Alert & verbal, ambulatory to ward, not notified. <i>Styl</i>										
1 ⁰⁰ _{pm} 9-26-04	Pain medication ordered Vicodin 5/50mg 40pm. <i>Styl</i>										
2020	5- No C/O noted. O-A+Ox3. (P) eye red - surrounding tissue bruised, (P) inner leg small wound - slightly dark. (P) inner heel dark discoloration noted wired. No acute distress noted @ this time. A- Pat alt in comfort RT DX. P- Cont POC <i>A. Jackson, R.N.</i>										
9-27-04 12am	5- No C/O noted. O- Resting in bed. No chgs noted from (previous) assessment. A- Pat alt in comfort RT DX. P- Cont POC <i>A. Jackson, R.N.</i>										
<table border="1"> <tr> <td>INMATE NAME (LAST, FIRST, MIDDLE)</td> <td>DOC#</td> <td>DOB</td> <td>R/S</td> <td>FAC.</td> </tr> <tr> <td><i>Natany maw</i></td> <td>141669</td> <td></td> <td>W/M</td> <td>Ref</td> </tr> </table>		INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.	<i>Natany maw</i>	141669		W/M	Ref
INMATE NAME (LAST, FIRST, MIDDLE)	DOC#	DOB	R/S	FAC.							
<i>Natany maw</i>	141669		W/M	Ref							



INFIRMARY NURSING PROGRESS NOTES

Date/Time	
9/27/04 @ 0900	<p>S: VOICES no Complaints.</p> <p>O: AAOx3 - Ambulatory in ward ad lib. Resp are even & regular. Skin warm & dry. Color WNL. Bruising to @ eye noted. Sutures to @ brow are intact & drainage noted. Wires to jaw intact. Dental wax given to pt for w/ wires irritating mouth.</p> <p>A: Altered health status R/T dx.</p> <p>P: Continue physician orders. Continue to monitor - MD. r/fu</p>
9/27/04 1400	<p>S: No complaints noted.</p> <p>O: A+Dx3. Ambulatory on ward ad lib. Wires to mouth intact. @ eye remains bruised. No distress noted @ present.</p> <p>A: Altered health status R/T dx.</p> <p>P: Cont physician orders. ———— C. Willis #10</p>
9/28/04 0000	<p>S: "I am ok"</p> <p>O: Alert & oriented x3. Respiration even & unlabored. Sutures noted to @ ante eye brow. Wires to jaw intact. Bruises noted to @ & leg. MAGEW. No complaints noted @ present.</p> <p>A: Altered health status R/T dx</p> <p>P: Continue to provide prn meds as need & follow MD orders ———— M. Bange</p>



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Vital Signs Flow Sheet

Patient Name: Nation, Marvin 144669

Date of Birth: [REDACTED]

TEMPERATURE

Date	9/26/07	9/27	9/27	9/28	9/29	9/30	9/30	10/1	10/5										
Time	2:00	6:10	2:00	04:00	5A	5A	11A	5P	5A										
104																			
102																			
100																			
98				98.6	97.3														
96	97.4	96.9	96.7	96		96.5	97	97.5	96.2										

BLOOD PRESSURE

260																			
240																			
220																			
200																			
180																			
160																			
140																			
120		122	130					120											
100	110			116			100	90		98	120								
80	80	86	68	80	90			86											
60					60		60	60		62	54								
40																			
20																			

PULSE

160																			
140																			
120																			
100																			
80	90		82				72	76		74									
60		76		78	64				72		72								
40																			

RESPIRATIONS

40																			
20	20	20	18	20	20		20	20											
10									16	18	20								

**INFIRMARY ADMISSION**

INMATE NAME: Nation, Mawn DOC# 181669

ADMISSION DATE: 9/26/14

ADMITTING DIAGNOSIS: S/p MCA FX. Lt jaw
united.

ADMITTING PHYSICIAN: Rash

ESTIMATED LENGTH OF STAY: _____

~~#~~ 141669

KEY/DIRECTIONS:

- PC Assessment done; changes found outside established

PHYSICAL ASSESSMENT:

PAIN AS RELIEVED BY MEDS. INDICATE IN PROGRESS NOTES

IV THERAPY:	TYPE

C-D-INT. JUGULAR
#15-16 - EXT. JUGULAR

SITE #1

TYPE

CONDITION

SITE #2

TYPE

CONDITION

TIME DRESSING CHANGED

TIME TUBING CHANGED

RESTART: CATH GAUGE

TIME

LOCATION #

INCISIONAL/WOUND CARE:

LOCATION/IDENTIFY SITE

SUTURES/CLIPS

DRAINS, TYPE

DRAINAGE TYPE

TIME DRSG.
CHANGED

SIGNATURES/TITLES:

PATIENT CARE NOTES

9 | 26 | 4 | 8034 | Lt. Leg wounds, healing slightly well

Nations

Baptist
HEALTH

DISCHARGE INSTRUCTIONS

Patient Information

Date: 9/26/04 Discharged to: ☒ Home ☐ Home with Home Health ☐ Assisted Living
☐ Home with equipment: ☐ Wheelchair ☐ Cape ☐ Walker ☐ Crutches ☐ Oxygen ☐ Other _____

DISCHARGE INSTRUCTIONS:

- Diet: ☐ Regular ☒ Special: Full liquids / Pureed
- Activity per physician's instructions. Call physician if you have questions.
- Treatment to continue at home: Saline Mouth Rinses prn;
"Wire Cutters"
- Physician pre-printed instructions reviewed and provided
- Other pre-printed instructions provided: (list) _____

FOLLOW-UP APPOINTMENT(S):

Dr. Kear 277-3492 call Day _____ Date _____ Time _____ ☐ AM ☐ PM
 Dr. for Wednesday Am F/U Day _____ Date _____ Time _____ ☐ AM ☐ PM

VACCINATIONS

Patient up to date on:

- ☐ Flu Vaccine (October - March) If No: ☐ administered ☐ contraindicated
☐ Pneumonia Vaccine (within the last 5 years) If No: ☐ administered

TARGET EDUCATION

- ☐ Smoking cessation ☐ Low-molecular weight heparin
☐ Coumadin ☐ Insulin ☐ Pain medication

NEW MEDICATIONS

- ☐ Education for new medications provided ☐ Prescriptions given (if applicable)

Drug Name	Dose	Frequency	Prescription Given	Education Provided
1.				
2.				
3.				
4.				
5.				
6.				

CONTINUE THESE MEDICATIONS:

Drug Name	Dose	Frequency	Drug Name	Dose	Frequency
1. <u>Continue Home Meds</u>		<u>→ Crush meds</u>			
2.					
3.					
4.					
5.					

Time of Discharge: 1150 ☒ a.m. ☐ p.m. Method of Discharge: ☐ Wheelchair ☐ Stretcher ☐ Carried (Infant) ☐ Other _____

I understand the above instruction(s) I have received my personal belongings, home medication(s), follow-up instructions and prescriptions (if applicable.)

Nurse: UAW Date: 9-26-04

Patient/Patient Rep: Mr. Nations Date: _____

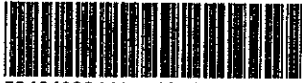


DI 1440

White- Medical Record

Yellow- Patient

Form DI 14405 Revised 6/02/04 Page 1 of 2



%
E040600461 NATION, MARVIN
DOB: 09/24/04 Age: 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A

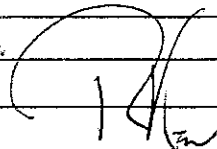


PHYSICIAN'S ORDERS

Height: _____ Weight: _____

Drug Sensitivities and Allergies ☐ NKDA ☐ Yes, list: _____

DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	Xmg	0 Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X 0 mg	X mg	AD AS AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	ORDERS For <u>KILBY</u> <u>NATION, MARVIN</u>
9/26/04	0915	<p>① Procedure: ORIF ② check and upper jaw fractures</p> <p>② Nursing: ↑ HOB 45° for 2-3 days. Do not allow patient to lay of ② side of face. Mr. Nation is wired together. There are two wires, one on each side that could be cut in an emergency (choking, vomiting). He also has rubber bands that can be cut. He should have wire cutters available @ all times. May shower, brush teeth</p> <p>③ Diet: liquid/puree diet. feed via syringes q4h Entero TID 2 meals.</p> <p>④ Meds: ^{Vicodin} Lorazepam 1mg tid q4h prn pain Amoxicillin 250/500 sup - tid tid TID x 7 days.</p> <p>⑤ Pt to Dr Korn Wednesday morning @ 10:00 will call for updt.</p> <p>⑥ Call Dr Korn 272-7482 for any problems.</p>
		Physician Signature: 



PH 350

DO NOT WRITE BELOW THIS LINE

faxed
9-27-04
CJ



FAX (334) 215-9126
Phone (334) -215-6678

Authorization for Release of Information

To: Baptist East

From: Kelly Prison
P.O. Box 11
Ont. Neig, AL 36057

Patient: Nation, Marvin

Inmate ID No: 141669

Alias: _____

Social Security No: _____

Date of Birth: [REDACTED]

Date(s) of Service: Sept 2004

I hereby authorize the above named provider to release to Prison Health Services, Inc. or any of its representatives the following confidential information:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care | |
| <input checked="" type="checkbox"/> Admission | <input checked="" type="checkbox"/> Discharge |
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Special Studies Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Immunization History |
| <input type="checkbox"/> Psychiatric Summary Report | <input type="checkbox"/> Drug Treatment History & Counseling Reports |
| <input type="checkbox"/> Other Records _____ | |
- (Specify information requested)

This authorization shall remain in full force and effect until withdrawn in writing by me. I hereby release and agree to hold provider harmless from any and all liability that may result from such release of information.

X Marvin Nation
(Patient's Signature)

9/27/04
(Date)

[Signature]
(Witness's Signature)

9/27/04
(Date)

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment of the named patient.

Charlotte Foster 9/27/04
(Signature and Title for PHS) (Date)



0426800461 NATION,MARVIN



Baptist Health

I/P AND O/P

ADMISSIONS AND FACESHEET

										FC 18		INIT LOS	
PATIENT NO 0426800461		DATE 09/24/04		TIME 1412P		SEX M		AGE 38Y		TYPE T M		EOS SUR	
NAME & ADDRESS NATION,MARVIN STATON CORRECTIONAL 2690 MARION SPILLWAY RD ELMORE AL 36205		DOB 02/29/76 128Y		SSN (334)567-1548		EMPLOYER AUTAUGA		EMP PH#		OCC EMP STAT EMP ID.		NOT EMPLOYED	
NAME & ADDRESS PRISON,HEALTH P O BOX 967 BRENTWOOD TN 37024-0967		DOB 02/29/76 128Y		SSN (334)395-5973		EMPLOYER SPONSOR		EMP PH#		OCC EMP STAT EMP ID.		SELF EMPLOYED	
NAME & ADDRESS PRISON,HEALTH P O BOX 967 BRENTWOOD TN 37024-0967		DOB 02/29/76 128Y		SSN (334)395-5973		EMPLOYER SPONSOR		EMP PH#		OCC EMP STAT EMP ID.		SELF EMPLOYED	
NAME & ADDRESS		HM		PH#		WK							
INSURANCE CARRIER PRISON HEALTH SERVICES		INSURED NAME PRISON,HEALTH		REL TO INSURED									
SUBSCRIBER ID# 416116816 / 141669		GROUP NAME STATON COORECTIONAL		GROUP NUMBER NATION,MARTIN		CONTACT		CITY/STATE/ZIP		ELMORE		AL 36205	
GROUP PHONE# (334)567-1548		APPROVAL#											
CONTACT ADDRESS 2690 MARION SPILLWAY RD													
INSURANCE CARRIER		INSURED NAME		REL TO INSURED									
SUBSCRIBER ID#		GROUP NAME		GROUP NUMBER		CONTACT		CITY/STATE/ZIP					
GROUP PHONE#		APPROVAL#											
CONTACT ADDRESS													
INSURANCE CARRIER		INSURED NAME		REL TO INSURED									
SUBSCRIBER ID#		GROUP NAME		GROUP NUMBER		CONTACT		CITY/STATE/ZIP					
GROUP PHONE#		APPROVAL#											
CONTACT ADDRESS													
DIAG CODE DIAGNOSIS		ALLERGIES		P		PT CL							
MANDIBULAR AND MAXIALRY FRACTUR				%									
ACCIDENT TYPE		NATURE OF ACCIDENT		ACCIDENT DATE		TIME							
ARRIVAL MODE		REFERRING FACILITY		CHURCH/DENOMINATION		RN							
OTHER													
ADMITTING PHYSICIAN		PRIMARY CARE PHYSICIAN											
361 KEAN,RICHARD A													
ATTENDING PHYSICIAN		REFERRING PHYSICIAN											
361 KEAN,RICHARD A													
LOCATION		E/R PHYSICIAN											
ADMISSION TYPE													
ELECTIVE													



FS 100

Last Printed: 09/24/2004 14:13:17

09/24/04

E00



%

E0426800461 NATION, MARVIN
DO [REDACTED] Age: 38Y MR #: 252786
Admit Date: 09/24/04 1412P
361 KEAN, RICHARD A



PHYSICIAN'S ORDERS

Height: _____ Weight: _____
Drug Sensitivities and Allergies ☐ NKDA ☐ Yes, list: _____

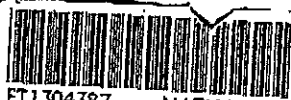
DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS, MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	Xmg	0 Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X 0 mg	X' mg	AD AS, AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	
9/25/04	0750	Toothbrush to bedside - begin brushing teeth today Scales to bedside - begin rinses 3-4 x daily ↓ IVF to 50cc/hr 12/25/04
9-25-04	1235	Morphine 2-6 mg. IV q2 nd post breakthrough pain p.o. Dr. Griggs/L. Weems, Rn 9/25/04 1235 14/25
Physician Signature: _____		



PH 350

DO NOT WRITE BELOW THIS LINE



ET1304387 NATION, MARVIN
DOB: 03/19/66 Age: 38Y MR #: 000000
Admit Date/Time: 09/24/04 1700P



Baptist HEALTH
PHYSICIAN ORDERS

Date	Time	Nurse's Initials	ANESTHESIA ACUTE PAIN MANAGEMENT ORDERS	
			1. Maintain IV access for 24 hours after epidural or intrathecal narcotic administration	
			2. Respiratory rate, sedation, pain scale every hour x 4hr, then every 4 hours.	
			3. Oxygen 2-4 L/min per nasal cannula PRN SaO ₂ . Less than _____ %	
			4. PRN Medications for itching: Nubain 1 - 2.5mg IV every 10 mins x 4 PRN every 4 hours Nubain 4mg SQ PRN every 4 hours Benadryl 25mg IV / PO PRN every 4 hours.	
			5. PRN medications for nausea and vomiting: Zofran 2mg IV and Dexamethasone 4mg IV as a single dose. If nausea/vomiting persists after 30 minutes, give Haloperidol 0.25mg IV and Metoclopramide 10-20mg IV. (Patients less than 35kg use Haloperidol 0.7mcg/kg). If nausea and vomiting persists after 30 minutes give: a. Promethazine (Phenergan) 12.5 - 25mg (dilute in 20cc IV every 4 hours PRN OR b. Meclizine (Antivert) 25mg PO PRN every 8 hrs OR c. Prochlorperazine (Compazine) suppository 25mg rectally PRN every 6 hours.	
			6. Page the ON CALL Anesthesiologist for questions relating to acute pain management.	
			7. Do not give additional narcotics or sedatives unless approved by Anesthesia.	
			8. <input type="checkbox"/> Pulse oximetry x _____ hours. May remove to ambulate.	
			<input checked="" type="checkbox"/> INTRATHECAL / EPIDURAL SINGLE NARCOTIC ADMINISTRATION: Medication: _____ mg/mcg of Morphine (Duramorph) Time given: _____ Intrathecal / Epidural orders, end 24 hours after drug given. Break through pain: Morphine _____ 2-6 mg IV PRN every 2 hrs PRN for pain. Toradol 30 mg IV PRN every 6 hours x 48 hours (greater than 65 yrs or less than 110 lbs. Give 15 mg) and hold for serum creatine greater than 1.2 Other: _____	
			<input type="checkbox"/> EPIDURAL INFUSION (PCEA) Medication: Fentanyl 5 mcg/ml and 0.125% Marcaine in 100ml NS. Continuous rate: _____ ml/hr Bolus dose: _____ ml. Bolus interval: _____ minutes. 4 hour dose limit _____ ml	
			BMC SOUTH <input type="checkbox"/> IV INFUSION (PCIA) Medication: <input type="checkbox"/> Morphine (1mg/ml) OR <input type="checkbox"/> Dilaudid (0.2mg/ml) (Continuous rate: _____ ml/hr) Bolus dose: _____ ml Bolus interval: _____ minutes 4 hour dose limit: _____ ml.	BMC EAST <input checked="" type="checkbox"/> IV INFUSION (PCIA) Medication: <input checked="" type="checkbox"/> Morphine (1mg/ml) OR Demerol 10mg/ml <input checked="" type="checkbox"/> Dilaudid (0.2mg/ml) (Continuous rate: <u>0</u> mg/hr) Bolus dose: <u>12.5</u> mg Bolus interval: <u>15</u> minutes 4 hour dose limit: <u>20mg</u> mg.
			MEDICATIONS FOR BREAK THROUGH PAIN FOR PCIA AND PCEA: Morphine _____ 2-6 mg IV PRN every 1 hour Dilaudid _____ 0.2 - 0.6mg IV PRN every 1 hour Demerol _____ 25 - 50mg IV PRN every 4 hours Toradol 30mg IV PRN every 6 hours x 48 hours (greater than 65 yrs or less than 110 lbs give 15mg and hold for serum creatine greater than 1.2) D/C PCIA or PCEA (remove epidural catheter) if no bolus is required for 12 hours. NOTE: If RR less than 8/min and/or patient is difficult to arouse, stop PCIA/PCEA and call the On-Call Anesthesiologist. Give Narcan 0.1 mg IV every one minute PRN to a max of 0.4 mg	
			Physician Signature: <u>Dr. R. Karmali</u> Date: <u>9/24/04</u>	



White - Medical Record

Yellow - Pharmacy

Form # PH 35011 Rev. 06/30/04

Q. Karmali RN 0040 9/25/04

PHYSICIAN'S ORDERS

USE BALL POINT PEN ONLY AND PRESS FIRMLY!

MHR 09/04

ALLERGIES

NKA

Weight

Another brand of generically equivalent product may be dispensed unless checked or initiated

CRT Order #	PHYSICIAN'S ORDERS
1	Admit to 1 North, Dr. Richard A. Kean
2	Dx: <u>(L) ZMC fx</u> , <u>(L) alveolar segment fx</u>
3	Condition: <u>satisfactory</u>
4	Procedure: <u>ORIF (L) zmc fx, upper jaw fx = arch bars.</u>
5	VS <u>q 4 hours</u>
6	Allergies: <u>NKDA</u>
7	Activity: <u>up with assistance</u>
8	Nursing: <u>Elevate HOB 45°</u> <u>Yankauer suction to bedside</u> <u>Ice packs to jaw for 48 hours</u> <i>N/A per Dr. Kean</i> <u>Gauze packs to mouth bilaterally for 30 minutes, then prn</u> <u>Do not lay on (L) side of face!</u>

AI

EO426800461 NATION, MARVIN
DOB: 03/23/38 MR #: 252786
Admit Date/Time: 09/22/04 1412P
361 KEAN, RICHARD A

158-2

Date Ordered	Time Ordered	Transcribers Initials/Time	Physician Signature
1			
			Begin saline mouth rinses tomorrow, 3 - 4 x daily
			9. Diet: <u>clear liquid diet tonight. puree diet in am as tolerated</u>
			10. IVF: <u>D5 1/2NS at 100cc/hr</u>
			11. Meds: <u>Morphine Sulfate via PCA pump per anesthesia</u> <i>DEMEROL</i> <u>Ancef 1 gram IV q 6 hours</u> <u>Solumedrol 125mg IV q 6 hours</u> <u>Phenergan 25mg IM or Supp q 4 hours prn N/V</u> <u>Pepcid 20mg IV q 12 hours</u> <u>A & D ointment to bedside, apply to lips prn, avoid corners of mouth</u>
			12. Labs: <u>6</u>
			13. Notify MD for Temp > 101.5°, HR > 140 < 40, SBP > 180 < 80, DBP > 110, severe pain or bleeding, any questions at 277-3492

ADDRESSOGRAPH

Dr. Kean

Date Ordered	Time Ordered	Transcribers Initials/Time	Physician Signature
2			
			14. Patient is wired together! He has two wires - one on each side that should be cut with a wire cutter in case of emergency (nausea/vomiting/choking). He also has some rubber bands in place. (can be cut too).
			15. Call me for any vision changes or severe eye pain or swelling.
			16. Neosporin to <u>(L) eyebrow incision</u> now and later to bedside.
			17. <u>60cc syringe with tip, Red Robinson cath cut to 6" for feeding</u>

ADDRESSOGRAPH

Date Ordered	Time Ordered	Transcribers Initials/Time	Physician Signature
3			

6/24 BC 413
C 9/14/04
A. Houe, RN 9/25 0040



1582
E0426900461 NATION, MARVIN
DOB: [REDACTED] Age: 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A



PHYSICIAN'S ORDERS

Height: _____ Weight: _____

Drug Sensitivities and Allergies ☐ NKDA ☐ Yes, list: _____

DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE	DO NOT USE	CORRECT USE
'u' or 'U'	Unit	MS, MSO4 MgSO4	Spell out words	TIW	Spell out words	Per os or OS	Spell out by mouth/oral
IU	International Unit	Xmg	0 Xmg	µg	microgram	BT	Spell out Bedtime
QD/QOD	Spell out words	X.0 mg	X mg	AD AS AU	Spell out words	QN or qn	Spell Out Nightly or at Bedtime

Date	Time	
9/26/04	0915	(1) Discharge IU and IV meds prior to discharge
		(2) Discharge to home prior - Staten Kilby
		(3) Discharge 2 60cc syringes 2 cath tips and two Reddown catheters.
		(4) Discharge 2 saline bottles
		(5) Discharge 2 orders to Staten prison.
		(6) Discharge 2 wire catheters!
		1 & 2 good?
		h. Weems 9/26/04
		J. Dabney 9/26/04
		Physician Signature: _____



PH 350

DO NOT WRITE BELOW THIS LINE

BAPTIST EAST
MEDICATION ADMINISTRATION RECORD
 ADMINISTRATION PERIOD: 09/26/04 07:00 TO 09/27/04 06:59

Name: NATION, MARVIN Admit: 09/24/04 MR #: E000252786
 Unit: E-1 N Med Surg Room: 158-2 Admitting Physician: Kean, Richard A., MD Ht:
 Account #: E0426800461 Reason for visit: no reason entered Wt:
 DOB/Age: [REDACTED] Years Sex: M Allergies: NKA

Page: 1
 Continued

Start Time	Stop Time	Drug Frequency	Dose Route	0700 - 1459	1500 - 2259	2300 - 0659	Chkd By
SCHEDULED MEDICATIONS							
09/24 21:00		Famotidine (Pepcid 20mg Inj. 2ml Vi) Twice Daily DILUTE TO 10ML WITH NS. IV PUSH OVER 2 MINUTES	20 mg / 2 mL IVP	0900 1800	2100 0600		AH
IV MEDICATIONS							
09/24 21:00		D5-1/2NS 50 mL/hr	1000 mL				AN
09/24 23:00		Cefazolin (Ancef 1gm Vial) Normal Saline Infuse Over 30 min Q8H CHANGED TO Q8H PER HOSPITAL PROTOCOL	1 gm / 5 mL 100 mL IVPB	0700 1100	1500 1900	2300 0300	AH
09/24 21:00		Solu medrol Syringe (Solu medrol 125mg/2ml *) Infuse Over 2 min Q6H	125 mg / 2 mL IV	0900 (AH)	1500 2100	0300	QH
PRN MEDICATIONS							
09/24 23:17		Promethazine INJ (Phenergan 25mg/ml INJ 1) Q4HPRN CNV For IV use-dilute to 10ml and IV PUSH over 1-2 minutes	25 mg / 1 mL IM	PRN			QH

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
				QH	Opie [Signature]

OMITTED DOSE CODES	
Circle Hours and Reason	
A-NPO	D-Nausea
B-Patient Refused	E-Patient Off Unit
C-Hold Dose	F-Other(see Notes)

SITE CODES			
Site, Route, & Initial Must be on Injectables			
Ant. Thigh	Gluteal Region	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8

BAPTIST EAST
MEDICATION ADMINISTRATION RECORD

ADMINISTRATION PERIOD: 09/26/04 07:00 TO 09/27/04 06:59

Name: NATION, MARVIN

Unit: E-1 N Med Surg Room: 158-2

Account #: E0426800461

DOB/Age: [REDACTED] Years Sex: M

Admit: 09/24/04

Admitting Physician: Kean, Richard A., MD

Reason for visit: no reason entered

Allergies: NKA

MR #: E000252786

Ht:

Wt:

Page: 2
Continued

Start Time	Stop Time	Drug Frequency	Dose Route	0700 - 1459	1500 - 2259	2300 - 0659	Chkd By
PRN MEDICATIONS							
09/24 23:17		Promethazine (Phenergan 25mg Supp) Q4HPRN CNV	25 mg / 1 Supp PR	PRN			ASH
09/24 23:18		Vitamins A & D (A&D ointment 5gm u/d) PRN KEEP AT BEDSIDE	1 App TOP	PRN			ASH
09/24 23:19		Triple Antibiotic Oint (Neospo (Neosporin Oint 15gm) PRN APPLY TO LEFT EYEBROW. KEEP AT BEDSIDE	1 App TOP	PRN			ASH
09/24 23:20		Meperidine PCIA (Demerol 10mg/ml PCIA 30) PRN BOLUS DOSE=12.5 MG LOCKOUT INTERVAL= 15MIN CONTINUOUS RATE=0 4 HOUR LIMIT=200 MG Analgesia via PCIA USE PUMP-DON'T EXCEED RATE/TIME **IV ONLY**	AS DIRECTED IV	PRN			ASH
09/24 23:20		Nalbuphine (Nubain 20mg/ml IJ 1ml) Q4HPRN FOR ITCHING WHILE ON PCE/EPIDURAL	4 mg / 0.2 mL SUBCUTANEOUS	PRN			ASH

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
				ON	Opul [Signature]

OMITTED DOSE CODES	
Circle Hours and Reason	
A-NPO	D-Nausea
B-Patient Refused	E-Patient Off Unit
C-Hold Dose	F-Other (see Notes)

SITE CODES			
Site, Route, & Initial Must be on Injectables			
Anr. Thigh	Gluteal Region	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8

MEDICATION ADMINISTRATION RECORD

ADMINISTRATION PERIOD: 09/26/04 07:00 TO 09/27/04 06:59

Admit: 09/24/04

Admitting Physician: Kean, Richard A., MD

Reason for visit: no reason entered

Allergies: NKA

Ht:

We:

Continued

Start Time	Stop Time	Drug Frequency	Dose Route	0700 - 1459	1500 - 2259	2300 - 0659	Chkd By
		PRN MEDICATIONS					
09/24 23:22		Nalbuphine (Nubain 20mg/ml IJ 1ml) PRN X 4 DOSES EVERY 4 HOURS FOR ITCHING WHILE ON PCA/EPIDURAL	1-2.5 MG IV	PRN			AK
09/24 23:21		Diphenhydramine cap (Benadryl 25mg cap) Q4HPRN FOR ITCHING WHILE PCA/EPIDURAL IS IN.	25 mg / 1 Tab PO	PRN			
09/24 23:21		Diphenhydramine INJ (Benadryl 50mg/ml inj) Q4HPRN FOR ITCHING WHILE PCA/EPIDURAL IS IN.	25 mg / 0.5 mL IV	PRN			
09/24 23:21		Ondansetron (=Zofran) (Zofran 2mg/ml INJ 1ml S) PRN GIVE WITH DECADRON ONCE ONLY FOR NAUSEA OR VOMITING WHILE ON PCA/EPIDURAL. GIVE THESE FIRST. Give IV push over 2 minutes. May be given undiluted IV	2 mg / 1 mL IV	PRN			
09/24 23:21		Dexamethasone (=Decadron inj) (Decadron 4mg/ml inj. 1m) PRN GIVE ONLY ONCE WITH ZOFRAN FOR NAUSEA OR VOMITING WHILE ON PCA/EPIDURAL. GIVE THESE FIRST.	4 mg / 1 mL IV	PRN			AK

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
				AN	April Hays

OMITTED DOSE CODES	
Circle Hours and Reason	
A-NPO	D-Nausea
B-Patient Refused	E-Patient Off Unit
C-Hold Dose	F-Other (see Notes)

SITE CODES			
Site, Route, & Initial Must be on Injectables			
Ant. Thigh	Gluteal Region	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8

BAPTIST EAST
MEDICATION ADMINISTRATION RECORD
 ADMINISTRATION PERIOD: 09/26/04 07:00 TO 09/27/04 06:59

Name: NATION, MARVIN Admit: 09/24/04 MR #: E000252786
 Unit: E-1 N Med Surg Room: 158-2 Admitting Physician: Kean, Richard A., MD
 Account #: E0426800461 Reason for visit: no reason entered Ht:
 DOB/Age: [REDACTED] 38 Years Sex: M Allergies: NKA Wt:

Page: 4
Continued

Start Time	Stop Time	Drug Frequency	Dose Route	0700 - 1459	1500 - 2259	2300 - 0659	Chkd By
PRN MEDICATIONS							
09/24 23:21		Haloperidol (Haldol 5mg/ml IJ 1ml am) PRN GIVE ONLY ONCE WITH REGLAN FOR NAUSEA OR VOMITING NOT RELIEVED BY ZOPRAN AND DECADRON AFTER 30 MINUTES WHILE ON PCA/EPIDURAL. GIVE 2ND IF PATIENT WEIGHS <35 KG, GIVE 0.7 MCG/KG INSTEAD OF 0.25 MG DOSE	0.25 mg / 0.05 mL IV	PRN			
09/24 23:21		Metoclopramide IJ (Reglan 10mg/2ml IJ) PRN GIVE ONLY ONCE WITH HALDOL FOR NAUSEA OR VOMITING NOT RELIEVED BY ZOPRAN AND DECADRON AFTER 30 MINUTES WHILE ON PCA/EPIDURAL GIVE 2ND.	10-20 MG IV	PRN			
09/24 23:21		Promethazine INJ (Phenergan 25mg/ml INJ 1) Q4HPRN USE FOR NAUSEA OR VOMITING NOT RELIEVED BY HALDOL AND REGLAN AFTER 30 MINUTES WHILE PCA/EPIDURAL IS IN. DILUTE IN 20 ML For IV use-dilute to 10ml and IV PUSH over 1-2 minutes	12.5-25 MG IV	PRN			
09/24 23:21		Meclizine tab (Antivert 25mg tab) Q8HPRN FOR NAUSEA NOT RELIEVED BY HALDOL AND REGLAN WHILE PCA/EPIDURAL IS IN.	25 mg / 1 Tab PO	PRN			

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE

OMITTED DOSE CODES	
Circle Hours and Reason	
A-NPO	D-Nausea
B-Patient Refused	E-Patient Off Unit
C-Hold Dose	F-Other (see Notes)

SITE CODES			
Site, Route, & Initial Must be on Injectables			
Ant. Thigh	Gluteal Region	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8

BAPTIST EAST
MEDICATION ADMINISTRATION RECORD
 ADMINISTRATION PERIOD: 09/26/04 07:00 TO 09/27/04 06:59

Name: NATION, MARVIN
 Unit: E-1 N Med Surg Room: 158-2
 Account #: E0426800461
 DOB/Age: [REDACTED] 38 Years Sex: M

Admit: 09/24/04
 Admitting Physician: Kean, Richard A., MD
 Reason for visit: no reason entered
 Allergies: NKA

MR #: E000252786
 Ht:
 Wt:

Page: 5
 end of report

Start Time	Stop Time	Drug Frequency	Dose Route	0700 - 1459	1500 - 2259	2300 - 0659	Chkd By
PRN MEDICATIONS							
09/24 23:21		Prochlorperazine suppos (Compazine 25mg supp) Q6HPRN GIVE FOR NAUSEA OR VOMITING NOT RELIEVED BY HALDOL AND REGLAN WHILE PCA/EPIDURAL IS IN.	25 mg / 1 Supp PR	PRN			AK
09/24 23:21		Ketorolac (Toradol 30mg/ml 1ml inj) Q6HPRN USE FOR BREAKTHROUGH PAIN WHILE ON PCA. 15MG IF >65 YEARS OLD OR <110 POUNDS HOLD FOR SERUM CREATININE >1.2.	30 mg / 1 mL IV	PRN			
09/24 23:21		Naloxone (Narcan 0.4mg/ml IJ) PRN GIVE 0.1 MG EVERY 1 MINUTE UP TO 4 DOSES IF RESP <8/MIN OR PATIENT IS DIFFICULT TO AROUSE. STOP PCA AND CALL ANESTHESIA DC WHEN EPIDURAL/PCA IS DC'D	0.1 mg / 0.25 mL IV	PRN			
09/25 14:59		Morphine Sulfate INJ (Morphine 4mg/ml IJ 1ml) Q2HPRN FOR BREAKTHROUGH PAIN DOCUMENT PAIN LEVEL 0-10	2-6 MG IV	PRN			AK

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
				AK	April [Signature]

OMITTED DOSE CODES	
Circle Hours and Reason	
A-NPO	D-Nausea
B-Patient Refused	E-Patient Off Unit
C-Hold Dose	F-Other (see Notes)

SITE CODES			
Site, Route, & Initial Must be on Injectables			
Ant. Thigh	Gluteal Region	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8



EO426800461
NATION, MARVIN
DOB: [REDACTED] Age: 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A



MEDICATION ADMINISTRATION RECORD ☐ BMCE ☐ PRATTVILLE

ADMINISTRATION PERIOD:

TO:

PATIENT INFORMATION

NAME:	ROOM:	ADMIT:	MR #
UNIT:		ADMITTING PHYSICIAN:	HT:
ACCOUNT #		REASON FOR VISIT:	WT:
DOB/AGE:	SEX:	ALLERGIES:	PAGE:

END OF REPORT:

START TIME	STOP TIME	DRUG/DOSE ROUTE/FREQUENCY	0700-1459	1500-2259	2300-0659	Checked by:
MEDICATIONS						
9/24		D5 1/2 NS @ 100cc/hr				AN
9/24		Ancef 1g IV q 6hr	0900 AN 1500 AN	2100 AN	0300 AN	
		Solumedrol 125mg IV q 6hr	0900 AN	2100 AN	0300 AN	
		Pronergon 25g IM				
		Pronergon 25mg Supp				
		Peprid 20mg IV q 12°		1800 AN	0600 AN	
		Neosporin to @ elbow incision				
		Now + tube @ bedside				
		100cc syringe C cath tip Red				
		Rubber tip cut cut to 6" for feed				
	Note	call MD if any vision DS or severe eye pain or swelling				
9/25		D5 1/2 NS @ 50cc/hr				AN

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
						AN	Apurthore, R

OMITTED DOSE CODES

SITE CODES

Circle Hours and Reason

Site, Route, & Initial Must be on Injectables

A - NPO	D - Nausea	Ant. Thigh	Gluteal Reg	Deltoid Muscle	Abdominal
B - Patient Refused	E - Patient Off Unit	Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
C - Hold Dose	F - Other (see notes)	Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8





E0426800461 NATION, MARVIN
DOB: [REDACTED] 38Y MR #252
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A

NAME:
UNIT:
ACCOUNT #
DOB/AGE:

SEX:

START TIME	STOP TIME	DRUG/DOSE ROUTE/FREQUENCY
------------	-----------	---------------------------

MED

Nubain 1-2.5

Nubain 4mg

Benadryl prn

Zofran 2
Dexamet

Haloperi
metoclopr

Phene
Q4hrs prn

* dilute in 20cc IV *
Antivert 25mg po Q8hrs prn

Compazine Supp. 25mg rectally Q6hrs prn

Saline to bs - begin rinses 3-4x daily

new @ bedside

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE

OMITTED DOSE CODES

Circle Hours and Reason

A - NPO	D - Nausea
B - Patient Refused	E - Patient Off Unit
C - Hold Dose	F - Other (see notes)

SITE CODES

Site, Route, & Initial Must be on Injectables

Ant. Thigh	Gluteal Reg	Deltoid Muscle	Abdominal
Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8

MANAGEMENT ORDERS

1. Oxygen 2-4 L/min per nasal cannula PRN S₂O₂ less than _____ %

2. PRN Medications for itching
Nubain 1-2.5mg IV every 10 mins x 4 PRN every 4 hours
Nubain 4mg SQ PRN every 4 hours
Benadryl 25mg IV / PO PRN every 4 hours.

3. PRN medications for nausea and vomiting
Zofran 2mg IV and Dexamethasone 4mg IV as a single dose. If nausea/vomiting persists after 30 minutes give Haloperidol 0.25mg IV and Metoclopramide 10 20mg IV. (Patients less than 35kg use Haloperidol 0.2mg/kg)
If nausea and vomiting persists after 30 minutes give:
a. Promethazine (Phenergan) 12.5 - 25mg (dilute in 20cc IV every 8 hrs PRN OR
b. Meclizine (Antivert) 25mg PO PRN every 8 hrs PRN
c. Prochlorperazine (Compazine) suppository 25mg rectally PRN every 8 hours.

4. Page the On-Call Anesthesiologist for questions relating to acute pain management.

5. Do not give additional narcotics or sedatives unless approved by Anesthesia.

6. ☐ Pulse oximetry x _____ hours. May remove to ambulate.

7. ☐ INTRATHECAL / EPIDURAL SINGLE NARCOTIC ADMINISTRATION:
Break through pain: _____ mg/mg of Morphine (Duramorph). Time given: _____
Intrathecal / Epidural orders, end 24 hours after drug given.
Morphine _____ 2-8 mg IV PRN every 2 hrs PRN for pain.
Toradol 30 mg IV PRN every 6 hours x 48 hours
(greater than 65 yrs or less than 110 lbs. Give 15 mg) and hold for serum creatine greater than 1.2

8. ☐ EPIDURAL INFUSION (PCEA)
Medication: Fentanyl 5 mcg/ml and 0.125% Marcaine in 100ml NS. Continuous rate: _____ ml/hr
Bolus dose: _____ ml. Bolus interval: _____ minutes. 4 hour dose limit: _____ ml

9. ☐ IV INFUSION (PCIA)
Medication: _____
Bolus dose: _____ ml
Bolus interval: _____ minutes
4 hour dose limit: _____ ml

10. **MEDICATIONS FOR BREAK THROUGH PAIN FOR PCIA AND PCEA:**
Morphine _____ 2-6 mg IV PRN every 1 hour
Dilaudid _____ 0.2 - 0.6 mg IV PRN every 1 hour
Demerol _____ 25 - 50mg IV PRN every 4 hours
Toradol 30mg IV PRN every 6 hours x 48 hours
not serum creatine greater than 1.2

NOTE: OAC PCIA or PCEA (remove epidural catheter) if no bolus is required for 12 hours.
If RR less than 8/min and/or patient is difficult to arouse, stop PCIA/PCEA and call the On-Call Anesthesiologist. Give Narcan 0.1 mg IV every one minute PRN to a max of 0.4 mg

Physician Signature: _____ Date: 9/24/04



PATIENT INFORMATION



ADMINISTRATION PERIOD: 9/25/06 TO:

NAME:		ADMIT:	MR #
UNIT:	ROOM:	ADMITTING PHYSICIAN:	HT:
ACCOUNT #		REASON FOR VISIT:	WT:
DOB/AGE:	SEX:	ALLERGIES:	PAGE:
			END OF REPORT:

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
				EA	Edward R		Andrew Howe



MA 1200

EO426800461 NATION, MARVIN
DOB: [REDACTED] Age: 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A



**MEDICATION ADMINISTRATION
RECORD** ☐ BMCE ☐ PRATTVILLE

ADMINISTRATION PERIOD:

TO:

PATIENT INFORMATION

NAME:	ROOM:	ADMIT:	MR #
UNIT:		ADMITTING PHYSICIAN:	HT:
ACCOUNT #	SEX:	REASON FOR VISIT:	WT:
DOB/AGE:		ALLERGIES: NKA	PAGE:

END OF REPORT:

START TIME	STOP TIME	DRUG/DOSE ROUTE/FREQUENCY	0700-1459	1500-2259	2300-0659	Checked by:
MEDICATIONS						
9/24		D5 1/2 NS @ 100cc/h				
		Pain mg 10/60	10	4-10	4	AT 0200
		Solumedrol 125mg IV 60				AT 0200
		Pheny 25mg IM 40				
		Pheny 25mg Supp 2/4				
		Pepcid 20mg IV 120				AT 0600
		A & D Unit @ Bedside, Apply to lips for, Avoid Cerebral Mucous				AT 2300
		(NOTE) Call MD if any vision loss or severe eye pain or swelling				
		Neosporin to eye brows incision new tube @ Bedside				AT 2200
		100 cc Seprins to Cath tip Red Robbin Cath cut to 6" for feed				AT 2300

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE
						AT	Apic House

OMITTED DOSE CODES

SITE CODES

Circle Hours and Reason		Site, Route, & Initial Must be on Injectables			
A - NPO	D - Nausea	Ant. Thigh	Gluteal Reg	Deltoid Muscle	Abdominal
B - Patient Refused	E - Patient Off Unit	Right - Code 1	Right - Code 3	Right - Code 5	Right - Code 7
C - Hold Dose	F - Other (see notes)	Left - Code 2	Left - Code 4	Left - Code 6	Left - Code 8



MA 1200



ET1304387 NATION, MARVIN
DOB: [REDACTED] Age: 38Y MR #: 000000
Admit Date/Time: 09/24/04 1700P



**Baptist
HEALTH**

OR IMPLANT RECORD / CHARGE SHEET

BAPTIST MEDICAL CENTER

☐ South ☐ East ☐ Prattville

Description CMF modular set
Size/Quantity _____
Manufacturer Leibinger
Catalog Number _____
Serial Number _____

plate 54-05105 (x1)
6mm screws 52-17206 (x4)

Description _____
Size/Quantity _____
Manufacturer _____
Catalog Number _____
Serial Number _____

arch bar & 24 gauge wire

Description CMF modular set
Size/Quantity _____
Manufacturer Leibinger
Catalog Number _____
Serial Number _____

plate 54-08506 (x1)
6mm screws 52-20706 (x4)

Description Osteomed visadisk
Size/Quantity _____
Manufacturer _____
Catalog Number _____
Serial Number _____

ECD plate 214-0217 (x1)
2.0mm 6mm screws (x2)
8mm screw (x1)

Description _____
Size/Quantity _____
Manufacturer _____
Catalog Number _____
Serial Number _____

Description _____
Size/Quantity _____
Manufacturer _____
Catalog Number _____
Serial Number _____

Description _____
Size/Quantity _____
Manufacturer _____
Catalog Number _____
Serial Number _____

Surgeon: Kear
Signature: [Signature]

Surgery Date: 9-24-04
RN Procedure: OKIF ZMC

WHITE COPY - PATIENT'S CHART

YELLOW COPY - HOSPITAL

PINK COPY - MATERIALS MANAGEMENT



SU 370



EO426800461 NATION, MARVIN
 DOB: [REDACTED] Age: 38Y MR #: 252786
 Admit Date/Time: 09/24/04 1412P
 361 KEAN, RICHARD A



Baptist
 HEALTH

OPERATIVE SERVICES PLAN OF CARE

FOCUS: ALTERED RESPIRATORY STATUS ①

GOAL: meet by discharge from criteria or cleared by Anesthesia AEB adequate ventilation and perfusion

INTERVENTIONS:

- ☐ Maintain airway by chin lift, oral / nasal airway, endotracheal tube.
- ☐ Promote effective airway clearance by suctioning, CDB.
- ☒ Assess SAO₂, breath sounds, and signs of respiratory distress
- ☐ Administer oxygen PRN to maintain SAO₂ > 90%.
- ☐ Anticipate complications by having age appropriate emergency equipment available, and identifying those at risk.

Date: 9/24/04 Signature: [Signature]

FOCUS: SAFETY ②

GOAL: patient will sustain no physical injury

INTERVENTIONS:

- ☐ Side Rails up X2, stretchers in locked position, pad rails for children or restless patients
- ☒ Protect surgical sites and drains
- ☐ Remain at the bedside of a child or a confused patient
- ☐ Give verbal and manual reassurance taking into account the developmental level.
- ☐ Apply restraints if other measures fail.

Date: 9/24/04 Signature: [Signature]

FOCUS: ALTERATION IN COMFORT ③

GOAL: patient will express reasonable comfort level, minimal nausea / vomiting, Temperature > 96 degrees.

INTERVENTIONS:

- ☒ Assess both adult and pediatric level of discomfort by utilizing physical and emotional assessment.
- ☒ Provide non-pharmacological measures for comfort - positioning, reassurance, warming systems.
- ☒ Administer medications as ordered and document effectiveness.

Date: 9/24/04 Signature: [Signature]

FOCUS: HEMODYNAMIC BALANCE ④

GOAL: discharge criteria met AEB vital signs WNL or anesthesia provider aware.

INTERVENTIONS:

- ☒ Maintain IV fluids/ site appropriate for age
- ☐ Strict I & O.
- ☐ Monitor VS, lung sounds to prevent fluid overload.
- ☐ Assess VS, heart rhythm, peripheral pulses. Invasive monitoring if appropriate

Date: 9/24/04 Signature: [Signature]

FOCUS: ALTERED LEVEL OF CONSCIOUSNESS ⑤

GOAL: meet by discharge from criteria or cleared by Anesthesia Provider AEB patient will verbalize needs and show compliance OR same as pre-op.

INTERVENTIONS:

- ☒ Assess patient's orientation / level of consciousness and reassure frequently to decrease anxiety.
- ☐ Check for signs of hypoxia, pain, or bladder distension
- ☐ Allow parent / significant other to visit if permissible.

Date: 9/24/04 Signature: [Signature]

FOCUS: POST-OP COMPLICATION ⑥

GOAL: patient will be free of postoperative complications. Anesthesia &/or MD aware if complications occur.

INTERVENTIONS:

- ☒ Monitor VS and assess patient frequently for complications.
- ☒ Monitor regional blocks / surgical site for circulation, sensation, movement and neuro checks.
- ☐ Check dressings and drains frequently for amount and color of drainage.
- ☐ Apply pressure and notify MD immediately for bleeding.

Date: 9/24/04 Signature: [Signature]

FOCUS: SKIN INTEGRITY ⑦

GOAL: no signs of skin breakdown while in PACU - especially with pediatric/geriatric/movement impaired population.

INTERVENTIONS:

- ☐ Position patient appropriately, move slowly
- ☐ Inspect and protect bony prominences as necessary and skin areas in contact with wound drainage, tape, drainage tubes, and pad sites.
- ☐ Assess extremities for circulatory impairment

Date: [Blank] Signature: [Blank]

FOCUS: ANXIETY ⑧

GOAL: patient exhibits appropriate coping mechanisms

INTERVENTIONS:

- ☒ Provide privacy, favorite objects, quiet environment.
- ☒ Explain tests/procedures to patient/family in simple concrete terms appropriate for age or explain to parent if child
- ☒ Family members at bedside of child IF feasible and inform family members for extended stays.

Date: 9/24/04 Signature: [Signature]

FOCUS: POST-OP INSTRUCTIONS ⑨

GOAL: patient / family exhibits understanding of instructions

INTERVENTION:

- ☒ Explain procedures/treatments to patient or to parent if child
- ☒ Instruct to deep breathe and cough, PCA pumps, spinal precautions
- ☒ Discharge instructions given and explained to patient/significant other parent and verbalizes understanding

Date: 9/24/04 Signature: [Signature]





EO426800461 NATION, MARVIN
DOB: [REDACTED] 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A



Baptist HEALTH
PHYSICIAN ORDERS

Date	Time	Nurse's Initials	ANESTHESIA PERIOPERATIVE ORDERS
9/24/04			1. EKG if none available within the last two years for any patient 50 or older. 2. Pregnancy test for women of childbearing age who believe they may be pregnant. 3. Obtain bedside glucose measurements on IDDM patient. Notify Anesthesia if Glucose < 70 or > 200. 4. May start IV with lidocaine local infiltration and bolus up to 1000ml of LR or NS for adults.
			1. MEDICATIONS FOR ANALGESIA: Morphine ____ 2 - 5 mg IV PRN every ____ 5 minutes, to a total of 30mg Dilaudid ____ 0.1 - 0.5mg IV PRN every ____ 5 minutes, to a total of 3mg Demerol ____ 25 - 50mg IV PRN every ____ 5 minutes to a total of 100mg Toradol ____ 30mg IV PRN every 6 hours x 48 hours. (> 65 yrs or <110 lbs give 15mg if OK with surgeon.) Hold Toradol if serum creatinine is > 1.2.
			2. MEDICATIONS FOR POST OPERATIVE NAUSEA AND VOMITING: Zofran 2mg IV and Dexamethasone 4mg IV as a single dose. If nausea/vomiting persists after 30 minutes give Haloperidol 0.25mg and Metoclopramide 10 - 20mg IV. (Pts < 35kg use Haloperidol 0.7 mcg/kg.) If nausea and vomiting persists after 30 minutes, give: a. Promethazine (Phenergan) 12.5 - 25mg IV every 6 hours PRN b. Meclizine (Antivert) 25mg PO every 8 hours PRN c. Prochlorperazine (Compazine) suppository 25mg every 6 hours PRN.
			3. MEDICATIONS FOR ITCHING: Nubain 1 - 2.5mg IV PRN every 10 minutes x 4 doses every 4 hours Nubain 4mg SQ PRN x 1 dose Benadryl 25 - 50mg IV PRN x 1 dose
			4. CARDIOVASCULAR MEDICATION: Notify Anesthesia for heart rate < 40 Symptomatic patient with a heart rate <40 give Atropine/Robinol ____mg IV. Notify Anesthesia for SBP > 200 and/or DBP >110 and give: Labetalol 5 - 10 mg IV PRN every 5 minutes, to a total dose of ____ 40 mg Hydralazine 5 - 10mg IV PRN every 15 minutes, to a total dose of ____ 20mg Other: _____ Notify Anesthesia for SBP <80 and give: Ephedrine 5 - 10mg IV PRN every 5 minutes, to a total dose of 50mg OR Ephedrine 25mg IM x 1 dose Notify anesthesia for chest pain and order 12 lead EKG.
			5. Oxygen 2 - 4 L/min nasal prongs or 10L/min face mask upon PACU admission, or SaO2 < 90%.
			6. PCXR for a patient with SOB, notify Anesthesia.
			7. Intubated patient - ABG x 1.
			8. PCXR for a patient that had a central line placed perioperatively.
			9. Updraft of 0.5cc Ventolin in 2.5cc NS PRN for wheezing and SOB
			10. A patient that had a spinal, epidural or nerve block may be discharged to the floor when hemodynamically stable awake and alert.
			11. May discharge the patient from PACU when discharge criteria is met
			12. Obtain bedside glucose measurements on IDDM patient. Notify Anesthesia if Glucose < 70 or > 200
			PEDIATRIC MEDICATIONS: 13. Nausea and vomiting: Zofran 0.1mg/kg x 1 dose for ages 2 - 12 years or Phenergan 0.25mg/kg x 1 dose. Pain: Morphine 0.1 mg/kg x 1 dose. May repeat every 10 minutes OR Demerol 1 mg/kg x 1 dose, may repeat every 10 minutes, OR Tylenol 10mg/kg x 1 dose, OR Ibuprofen 5mg/kg x 1 dose.
			Physician Signature: _____ Date: 9/24/04



PH 350

White - chart

Yellow - Pharmacy

Form # PH 35010 Revised 1/04



%

EO426800461 NATION, MARVIN
DOB: [REDACTED] Age: 38Y MR #: 252786
Admit Date/Time: 09/24/04 1412P
361 KEAN, RICHARD A




POSTOPERATIVE PROGRESS RECORD

Date	Time	
		Surgeon: KEAN Assistant: BEU
9/24/04	1850	
		Preop Dx: (L) zygomatic-maxillary complex fracture (maxilar fx-closed), (L) alveolar segment fracture (open) (maxilla)
		Postop Dx: S2M1
		Procedure: ORIF (L) ZMC fx - multiple approaches ORIF (L) maxillary alveolar segment fx 2nd b211 E WIF
		Findings: m2bocclusion
		Specimen:
		EBL: 100cc
		M.D. Signature: [Signature]



PN 300

☐ SOUTH 286-2843
☐ EAST 244-8448
☐ PRATTVILLE 361-4239


 B0426500476 NATION, MARVIN
 DOB: [REDACTED] Age: 37Y MR #: 567116
 Admit Date/Time: 09/21/04 1428P
 920 ALEXANDER, D GREGORY

ealth

Page 1 of 1

ncy Room Prescription Form

PRESCRIPTION FORM

Weight	Phone	Allergies	Location South	
MEDICINES PRESCRIBED		If non, check this box: <input type="checkbox"/>		
VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND				
Name/Strength	Number	Schedule / Duration	No Refills	Refills
1. Lorcel 4 # 20 794h pm pr			<input type="checkbox"/>	
2.			<input type="checkbox"/>	
3. Azman 500 # 21 7 tid			<input type="checkbox"/>	
4.			<input type="checkbox"/>	
5.			<input type="checkbox"/>	

Emilio Belaval
 AL - 22654
 DEA - BB5295248

Joel Sullivan
 DEA - AS2020066
 ARN - 10094

Ronald A. Shaw
 AL - 6388
 DEA - AS5646813

Julio Enrico Rios
 ARN - 21678
 DEA - BR2471326

Wallace Falero
 AL - 9405
 DEA - AF1692119

James M. Bradwell
 DEA - BB6422086
 AL - 22767

David G. Alexander
 DO - 657
 AA3259226

John Moorehouse
 DEA - AM6869119
 ARN - 7151

Jessie Austin
 DEA - AA8394075
 ARN - 8595

Tom Decaro
 DEA - AD2628355
 ARN - 11369

Henry Kurusz III
 DEA - AK2572116
 AL - 22198

Victoria L. Beckman
 DEA - BB62553885
 AL - 22440

Steven G. O Mara
 DEA - BO1736074
 DO - 713

Brad Frisbie
 DEA - BF2524583
 ARN - 15396

Thomas Arnold
 DEA - AA9548655
 ARN - 16275

Paul Tanaka
 ARN - 7153
 DEA - 8922-896

Label all prescriptions
 No refills

Product Selection Permitted

M.D./D.O.

Dispense as Written

M.D./D.O.

BSB-0082 (06/02)

Baptist Health
Emergency Room
Discharge Instructions

Page 1 of 1



B0426500476 NATION, MARVIN
 DOB: [REDACTED] Age: 37Y MR #: 567116
 Admit Date/Time: 09/21/04 1428P
 920 ALEXANDER, D GREGORY

DISCHARGE INSTRUCTIONS

Weight	Phone	Allergies	Location South
--------	-------	-----------	-------------------

MEDICINES PRESCRIBED

If non, check this box: ☐

VOID IF NOT PRINTED WITH CRANBERRY BACKGROUND

Name/Strength	Number	Schedule / Duration	No Refills	Refills
1. <i>Lorazepam (H) 20 mg q4h PRN</i>			<input type="checkbox"/>	
2.			<input type="checkbox"/>	
3. <i>Doxycycline 100mg H 21 - tid</i>			<input type="checkbox"/>	
4.			<input type="checkbox"/>	
5.			<input type="checkbox"/>	

INSTRUCTION SHEET(S) GIVEN

- ☐ Asthma ☐ Crutches
☐ Back Pain ☐ Fever
☐ Cast / Splint Care ☐ Fracture

- ☐ Head Injury
☐ Otitis Media
☐ Sprains / Bruises
☐ STD

- ☐ Threatened Ab
☐ Vomiting / Diarrhea
☐ Wound Care
☐ Other(s) _____

Return for signs of infection
 > Redness
 > Swelling
 > Drainage
 > Heat

Additional Instructions:

*To Dr. Craig Chapman 1 PM tomorrow
 I am to have a follow up
 Call Dr. McQuay 281-5322 or our scheduler
 PCU V.S. for family member*

Referred to:

- ☐ Dr. _____
 Phone: _____
☐ Call on next business day for follow-up appointment
 in _____ days / weeks ☐ next available

- ☐ Return to Emergency Dept in _____ hours / days for recheck
☐ If no improvement or your condition worsens, call your private physician
 or return to the Emergency Department for a recheck
☐ Learning needs assessed ☐ Instructions Modified: _____
☐ Education provided on new medication _____

I understand that the treatment I have received was rendered on an emergency basis and is not meant to replace complete care from a primary care provider or clinic. Furthermore, I may have been released before all of my medical problems were apparent, diagnosed, and/or treated. If my condition worsens, I have been instructed to call my primary care provider or return to this facility or the nearest emergency center. I understand that I should NOT drive or perform hazardous tasks if my medication or treatment causes drowsiness. I have read and understand the above, received a copy of this form and applicable instruction sheets, and I will arrange for follow-up care. If diagnostic tests indicate a need for modification in therapy, you will be notified at the phone number you provided.

- ☐ Patient
☐ Relative
☐ Other _____

Time Released > 1945 Hrs

Instructed By:

Physician:

WORK/ SCHOOL STATEMENT from the Emergency Department

Patient Name	Date
--------------	------

- ☐ Patient was seen by Dr. _____ ☐ May return to restricted duties for _____ days*
☐ No athletics / physical education: _____ days* Restrictions: _____
☐ May return to work / school without restrictions
☐ Will require time off work / school. Estimated time: _____ days* ☐ _____ was here with relative/ child.
☐ Must be reevaluated by family / occupational physician before returning to school / work. ☐ Other: _____

CORRECTIONAL MEDICAL SERVICES
RELEASE OF INFORMATION AUTHORIZATION

Pineaw

Nathan, MARK 141669
Name of Inmate Inmate ID Number / Date of Birth
KLP Baptist Med. Ctr. 3-5-01
Facility Releasing Information Date medical center Blvd.

DR. PEINO WILSON Salem North Carolina 27157

I hereby give my consent to Correctional Medical Services and the above named facility to release the following information from my medical record to the facility/provider listed below:

- ☒ Records related to treatment of Pancreatitis
from _____ to 2000
- ☐ Physician/Provider's summary of my diagnosis, medications, treatments, prognosis and recent care.
- ☐ Admission Reports ☐ Discharge Reports ☐ Operative Summary Reports
- ☐ X-Ray Reports ☐ Special Studies Reports ☐ Laboratory Reports
- ☐ Immunization History ☐ Mental Health Records ☐ Psychiatric Summary Report
- ☐ Drug Treatment History and Counseling
- ☐ Other Records _____

Naples Inc.
Kilby Correction Center
Facility/Provider to Receive Information P.O. Box 11 - Mt. Vernon, AL 36057

This information has been disclosed to you from records whose confidentiality is protected by State law. State regulations prohibit you from making any further disclosure of this information without the prior written consent of person to whom it pertains.

I understand this authorization shall remain in full force and effect for the period of _____
_____ from today's date unless withdrawn in writing by me

I sign this willingly and I release Correctional Medical Services and the facility from any liability which may result from such release of information.

Mark Nathan
Inmate Signature

3-5-01
Date

Robert [Signature]
Witness

R. Burkette, Jr.
Witness

sent 3-5-01 @

N.C. BAPTIST HOSPITALS,
MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43
10/09/1999

Dana Chambers-Kellett, M.D.
212 29th Avenue
Hickory, NC 28601

RE: Endoscopic retrograde cholangiopancreatography (ERCP) of 10/6/99.

Dear Dr. Chambers:

I am writing to let you know that Mr. Nation returned for repeat ERCP, which I performed on 10/6/99. When he returned for the procedure, his blood work was normal, including a liver profile, electrolytes, and CBC.

Under general anesthesia, ERCP was performed. The pancreatic stent was removed, following which pancreatography revealed a dilated pancreatic duct up to approximately 8 mm in diameter with side branch changes consistent with Cambridge class IV chronic pancreatitis. The papilla had evidence of a prior sphincterotomy, which allowed easy biliary cannulation. This revealed a normal-sized bile duct and normal gallbladder. The distal bile duct tapered significantly, but there was no definite stricture and no upstream biliary dilatation. The procedure was well tolerated, and there were no complications.

IMPRESSION:

1. Severe chronic alcoholic pancreatitis (Cambridge class IV).
2. Resolution of pancreatic pseudocyst with pancreatic stenting, status post pancreatic stent extraction.
3. Distal common bile duct stenosis secondary to severe chronic alcoholic pancreatitis.

RECOMMENDATIONS: Overall, Marvin has been doing quite well. He states that, since he has had the stent placed, he has not been symptomatic. His pseudocyst, that had previously been seen, has resolved.

I have once again encouraged him to discontinue alcohol intake entirely. If he were to have recurrence of symptoms, my feeling is that he should undergo surgical management with a lateral pancreaticojejunostomy. He will continue his followup

N.C. BAPTIST HOSPITALS,
MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43

with yourself, but I would be happy to reassess him at your request should you feel that this is necessary.

Thank you very much for allowing us at the Wake Forest University School of Medicine to offer care to your patient.

Sincerely,

Benoit C. Pineau, M.D.
Gastroenterology

BCP/sib D 10/09/1999 T 10/10/1999 Doc# 694073 Job# 69

cc: Lawrence McClur Caldwell, MD
24 S Brady Street
PO Box B49
Newton, NC 28658

Dana Chambers-Kellett, MD
212 29Th Avenue
Hickory, NC 28601

James Comer Galther, M.D.
Catawba Valley Int Med
3411 Graystone Place
Conover, NC 28613

Benoit C Pineau, M.D.

Copy For: Benoit C Pineau, M.D.

ADMITTED: 10/06/1999 ACCT#: 010381979256 33Y M # 1457143 NATION, MARVIN KURT
 LOC: DHSP
 DR: PINEAU, BENOIT C 26710/ GIN
 PHYSICIAN COPY FOR DR: PINEAU, BENOIT C

MISC CHEMISTRY

TEST: AMYLASE LIPASE
 UNITS: U/L U/DL
 LO-HI: 0-200 4-24

10/07 + 0600 32 7

[Handwritten signature]

Receptor's Initials
 10-8-99
 Date Received

**Wake Forest University Baptist Medical Center
ERCP Report**

Todays Date: 10/6/1999

Patient Name: Marvin Nation

Paient ID#: 1457143

Exam Date: 05/24/1999

Attending Physician: Dr Ben Pineau

Referring Physician: Dr. Jamal Ibdah

INTRODUCTION:

33 year old male patient presents for an elective inpatient ERCP. The indication for this procedure was recurrent pancreatitis related to h/o ETOH use with a known pseudocyst on CT scan.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

The patient has been NPO since midnight an intravenous line was inserted. The patient's cardiac status, blood pressure, pulse and pulse oximetry was monitored.

MEDICATIONS: General Anesthesia

PROCEDURE:

The endoscope was passed with ease under direct visualization to the 2nd portion of the duodenum. The study was performed with a TJF-100 Olympus video duodenoscope.

EXAMINATION:

STOMACH: There was evidence of Billroth I anastomosis. There was food residue and retained secretions and bile present in the stomach.

DUODENUM: The duodenum appeared normal.

MAJOR PAPILLA: The major papilla appeared normal.

ERP: There was a 5 mm high grade stricture in the distal main pancreatic duct. The main pancreatic duct in the head of the pancreas was dilated to 12 mm. It was irregular in contour with ectatic side branches. There was a 1.5 cm x 2 cm cyst in the head of the pancreas communicating with the main pancreatic duct.

ERC: There was a smooth stenosis of the distal CBD in the intra-pancreatic portion measuring 10 mm. The remaining common bile duct, common hepatic duct, right and left hepatic ducts, intrahepatic ducts, cystic duct and gallbladder were normal.

THERAPY:

Without a prior sphincterotomy, an attempt to place 7 Fr 8 cm long single pigtail stent in the body of the pancreas was made. The procedure was successful. At completion of placement the stent position was ideal. The proximal end lay within the body of the pancreas. There was prompt drainage of clear pancreatic juice. A precut papillotomy was performed with a 5 Fr single-lumen needle-knife papillotome over the pancreatic stent. There were no immediate complications.

IMPRESSION:

1. Chronic pancreatitis (Cambridge class IV)
2. Pancreatic pseudocyst communicating with main pancreatic duct.
3. Distal CBD stenosis due to #1.

RECOMMENDATION:

Repeat ERCP with stent change in 8 weeks. If endoscopic therapy fails would recommend lateral pancreatojejunostomy.

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WAKE FOREST UNIVERSITY BAPTIST MEDICAL CENTER
WINSTON-SALEM, NC 27157

DISCHARGE ORDER and SUMMARY

PHYSICIAN TO FILL IN ALL BLACK AREAS
NURSE TO FILL IN ALL RED AREASINSTRUCTIONS ON BACK • DO NOT USE MEDICAL ABBREVIATIONS OR SYMBOLS
PLEASE PRINT

ADMIT DATE 10/6/99	DISCHARGE DATE 10/7/99	REFERRING PHYSICIAN Dana Chambers
REFERRING PHYSICIAN ADDRESS Hickory, NC		

NATION, HARVEY

33 W. 111 11 13
01038197 9256 AREA
PITTSBURGH, PA 15101Dana
Chambers
HickoryADMITTING / PRINCIPAL / SECONDARY /
COMPLICATIONS / CO-MORBIDITIES:

Chronic pancreatitis

ERCP + stent extraction

DATE OF ONSET OF PRESENT ILLNESS ESTIMATED DATE OF TERMINATION OF DISEASE DO NOT WRITE IN THIS AREA

SUMMARY DICTATED

INVASIVE LINES / DEVICES

DATE BY ☐ YES ☐ NO

DISPOSITION

LISTED BELOW ARE YOUR
MEDICATIONS & DOSAGESTimes to
Take DailyContinue
as BeforePrescrip-
tion GivenLISTED BELOW ARE YOUR
MEDICATIONS & DOSAGESTimes to
Take DailyContinue
as BeforePrescrip-
tion GivenInforma-
tion Given☐ NO MEDICATIONS NEEDED AT DISCHARGE

DIET: Your Diet is:

Low fat

ACTIVITY: ☐ No Restrictions ☐ Resume Same Activity ☐ Up with Crutches or Walker, Weight Bearing as Instructed ☐ Complete Bedrest
☐ DO NOT: ☐ Bend ☐ Sloop ☐ Lift ☐ Drive ☐ Move Furniture ☐ Do Strenuous Activity ☐ Climb Stairs
☐ Up as Tolerated ☐ OTHER:FOLLOW-UP: ☒ No Appointment Necessary ☐ Return Appointment in _____ Wks to Dr. _____Card to
be MailedCall Home Doctor
for Appointment

DISCHARGE PATIENT: V. D. Dr. Pinson

10/7/99 10:15

N. J. Jones

10/7/99

SPECIFIC DISCHARGE CARE INSTRUCTIONS (Nurse and/or Physician) - Dressings, Incision Care, Equipment, Instructional Materials

DATE
10/7NURSE / PHYSICIAN
SIGNATURE

INSTRUCTIONS

Follow discharge instructions given by doctor, read ERCP
booklet, and questions or problems call

Dr. G. Pinson 336-716-4621

ADMITTED: 10/06/1999 ACCT#: 010381979256

LOC. AMBS

33Y M

1457143 NATION, MARVIN KURT

DR: PINEAU, BENOIT C 26710/ GIN

PHYSICIAN COPY FOR DR: PINEAU, BENOIT C

TEST: PLT HCT RBC MCV RDW WBC SEG BAND Lymph MONO EOSN BASO
 UNITS: THOU G/DL % MIL FL INDEX THOU THOU THOU THOU
 LO-HI: 160- 14.0- 42.0- 4.7- 80.0- 11.5- 4.8- 1.6- 0.0- 1.0- 0.16- 0.0- 0.0-
 360 18.0 52.0 6.1 94.0 14.5 10.8 7.3 0.2 5.1 0.9 0.5 0.3

10/06 + 1056 219 14.5 42.4 5.01 84.6 13.3 8.8

TEST: PT PT FIBRINOGEN PTT-A
 UNITS: SEC INR MG/DL SEC
 LO-HI: 10.8- 180-363 <31
 13.9

10/06 + 1056 12.1 0.95 242 25.0

TEST: NA K CL CO2 GLUC (B) UN CREAT URIC CA PHOS CHOL PROT ALB TBILI DBILI ALK-P GOT LDH IRON
 UNITS: MEQ/L MEQ/L MEQ/L MEQ/L MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL
 LO-HI: 135- 3.5- 95.0- 22.0- 70.0- 8.0- 0.5- 2.5- 8.5- 2.5- 120- 6.0- 3.2- 0.1- 0.0- 30.0- 5.0- 90.0- 40.0-
 145 5.0 106 30 110 24.0 1.5 8.0 10.5 4.5 260 8.0 5.0 5.0 1.2 0.4 110 35.0 250 160

10/06 + 1056 140 3.9 96 30 92 8 0.7 9.2 7.5 4.5 0.9 0.3 92 15

bl
 Reviewer's initials
 10-7-99
 Date Received

PRINTED 10/06/1999 1810

PAGE 1 - END OF REPORT

Outpatient New Activity Cum

1457143 NATION, MARVIN KURT

RADIOLOGY REPORT

FINAL REPORT

PHYSICIAN COPY FOR PINEAU, BENOIT C

THE MEDICAL CENTER

DEPARTMENT OF RADIOLOGY

PATIENT NAME: NATION, MARVIN KURT
REQUISITION : 4042798
DATE DONE : 06/09/99
REFERRING DR: PINEAU, BENOIT C
RADIOLOGIST : LINK, KERRY

UNIT #: 1457143
LOCATION: WGIN
DATE READ: 06/10/99
ORDERING DR: PINEAU, BENOIT C
RESIDENT DR: LUNDELL, ANDREA

ADM DX: F/U
INDICATIONS: PANCREATIS STENT
INDICATIONS:
ACUTE ABDOMINAL SERIES, 6/9/99.

0220 IDX VISIT # 02693750

COMPARISON: 5/13/99.

INDICATION: 33-YEAR-OLD MALE STATUS POST PLACEMENT OF PANCREATIC
DUCT STENT.

FINDINGS:

ABDOMEN: A NEW PANCREATIC STENT PROJECTS OVER THE MID ABDOMEN.
MULTIPLE SMALL CALCIFIC DENSITIES PROJECT IN THE REGION OF THE
PANCREATIC TAIL. MULTIPLE SURGICAL CLIPS ARE LOCATED AT THE
GASTROESOPHAGEAL JUNCTION. THE BOWEL GAS PATTERN IS NORMAL.


CHEST: THE HEART AND MEDIASTINAL SILHOUETTE IS NORMAL IN SIZE AND
CONTOUR AND THE LUNGS ARE CLEAR.

CONCLUSION: STATUS POST PLACEMENT OF PANCREATIC STENT WITH
EVIDENCE OF CHRONIC CALCIFIC PANCREATITIS. PRIOR SURGERY AT THE
GASTROESOPHAGEAL JUNCTION. THE LUNGS ARE CLEAR.

I HAVE PERSONALLY REVIEWED AND INTERPRETED THIS IMAGE/IMAGES.

RESIDENT DR: LUNDELL, ANDREA
INTERPRETING DR: LINK, KERRY
SIGNED BY DR: LINK, KERRY

DATE AND TIME: 06/10/99 18:02

	
Reviewer's Initials	Date
	6/14
Date Received	

NATION, MARVIN

NCBH# 145 71 43

DATE: 6/9/99

HPI: This is a 33 year old white male with a history of pancreatitis with alcohol abuse, diagnosed 2 years ago. He has had no alcohol since 11/98. Apparently the patient was seen at Catawba Memorial as well as Forsyth Hospital in February and March of 1999 and was noted to have a new development of pseudocysts. He was admitted here on 5/20/99 with pancreatitis with a 3 cm pseudocyst at the head of the pancreas. He then underwent ERCP 5/24/99 revealing chronic pancreatitis, Cambridge class IV, and a pancreatic pseudocyst communicating with the main pancreatic duct. He had distal common bile duct stenosis due to the pancreatitis. A 7 French, 8 cm long, single pig-tail stent was placed in the body of the pancreas. The patient presents for follow-up.

The patient states that he has been doing very well since the first few days after he left the hospital on 5/25/99. He says that initially he vomited within the first few days so severely that he was afraid he might have dislodged his stent. Since that time, he has improved, and he has not vomited since the first few days after being home. He is eating well and gaining weight. He says that he feels that he can localize the plastic stent when he moves around. Also when he is hungry he can feel some pain in the area of the head of the pancreas and if he eats too much, he feels a fullness and a presence of the stent. In general, however, he says that he feels that he has done well. He is only taking 2-3 per day of his Demerol that he was discharged with. He took his last Demerol on Monday night and he has had no pain since that time. He says that his bowels are moving well. He is pleased at his progress and he is returning to work as a carpenter. He has not eaten.

MEDIATIONS: Demerol 100 mg prn (none since Monday and the patient has exhausted his supply); Phenergan about 1 per day taken at bedtime; Creon 1 tablet before meals; Prilosec 20 mg qd.

PHYSICAL EXAMINATION: WT 158.9 lbs, T 97.1, BP 131/80, P 87. In general this is a very pleasant white male who looks thin, but well nourished. He is in no acute distress whatsoever. HEENT: conjunctiva is pink; oropharynx is clear. Heart: grade II/VI systolic ejection murmur; otherwise no gallops or rubs. Lungs: CTA. Abdomen: flat abdomen; normal bowel sounds; no organomegaly or masses. The patient does have a well healed scar from his previous gastric surgery. There is essentially no significant tenderness noted in the abdomen. There is some mild tenderness noted in the epigastrium or over the head of the pancreas. There is also some mild tenderness in the left lower quadrant of the abdomen. Extremities: no edema.

IMPRESSION: Patient with alcoholic pancreatitis with new development of pseudocysts in 2/99 with placement of a pancreatic stent 5/24/99. The patient is doing well and returning to work. He is concerned about some possible dislodgment of the stent secondary to retching in the first day that he was home.

PLAN:

1. KUB was obtained prior to the patient's leaving clinic today. This showed no acute changes and showed the stent in place.
2. The patient's Creon was changed to Viokase. He was given a prescription for Viokase, #600, to take 6 with meals and 1-2 with snacks. He was given 5 refills.

NATION, MARVIN

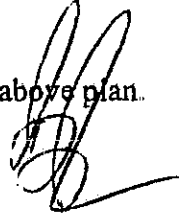
NCBH# 145 71 43

DATE: 6/9/99

Page 2

3. He will be given a 2 month return. He was advised to phone if there is any acute pain or change in condition.

Dr. Pineau has seen the patient and agrees with the above plan.



Claudia Mikulaninec, MSN, FNP
Section of Gastroenterology

Ben C. Pineau, M.D., F.R.C.P. (c)
Assistant Professor of Medicine
Section of Gastroenterology

CM/BCP/red/56

cc: Dr. Russell Howerton
WFUSM – Surgery

Medical records.

N.C. BAPTIST HOSPITALS, INC.

MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43

May 30, 1999

Dana Chambers-Kellett, MD
212 29th Avenue
Hickory, NC 28601

Dear Dr. Chambers-Kellett:

Thank you very much for asking me to see Mr. Nation in consultation. I saw him on 5/8/99 and a full note should have reached you by now.

On 5/6/99 he underwent a C.T. scan of the abdomen which revealed changes consistent with pancreatitis including a two times 1.7 cm pseudo cyst in the head of the pancreas, and a possible other 5.7 times 1.2 cm cyst in the intrapancreatic portion. The gallbladder was distended and the biliary tree was dilated.

On 5/24/99, I performed an ERCP under general anesthesia since we were unable to sedate him a few days before despite 300 mg of Demerol, 10 mg of Versed and 7.5 mg of Droperidol. We found evidence of a Billroth I anastomosis. There was some food residue and retained secretions in the stomach. There was a high grade stricture in the very distal pancreatic duct with upstream dilatation of the duct up to 1.2 cm in the body and tail. The side branches were dilated and ectatic, consistent with severe chronic pancreatitis. There was a 1.5 times 2 cm cyst in the head of the pancreas communicating with the main pancreatic duct. Cholangiography revealed a distal Common bile duct stenosis in the intrapancreatic portion of the Common bile duct with little evidence of upstream biliary ductal dilatation.

We were able to place a 7 French, 8 cm single pigtail pancreatic stent in the pancreatic duct, leading to prompt drainage of pure pancreatic juice. A pre-cut pancreatic sphincterotomy was performed over the stent with a needle knife, papillotome.

Impression:

1. Severe chronic alcoholic pancreatitis (Cambridge class IV).
2. Communicating pancreatic pseudo cyst in the head of the pancreas.
3. Distal Common bile duct stenosis, secondary to no. 1.

Recommendations: We will see how the stent helps him clinically. If he finds benefit, we will plan on changing the stent in eight weeks to a larger stent. If he does not respond, he will likely need a lateral pancreaticojejunostomy at which point good biliary diversion will have to be considered.

Copy For: Jamal Ahmad Ibdah, M.D.

N.C. BAPTIST HOSPITALS, INC.
MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43

Thank you very much for allowing me to participate in the care of your patient.
Please do not hesitate to call me if you have any questions or comments.

Sincerely,

Benoit C Pineau, M.D.
Gastroenterology

BCP/rmg D 05/30/1999 T 05/31/1999 Doc# 617593 Job# 46

cc: **Jamal Ahmad Ibdah, M.D.**

Dr. Caldwell, Newton, N.C. 28658

James Comer Gaither, M.D.
Catawba Valley Int Med
3411 Graystone Place
Conover, NC 28613

Copy For: **Jamal Ahmad Ibdah, M.D.**

05/27/1999
15:04

NC BAPTIST HOSPITAL

LABORATORY RESULTS
PAGE 1

NAME: NATION, MARVIN KURT

*** PATIENT DISCHARGED ***

H# : 1457143

LOC: 4W

ROOM: 0481A

AGE: 33Y SEX:M

ACCT: 010381979139 DR: IBDAH, JAMAL A. 28640/GIN

H5308 COLL: 05/20/1999 17:10 REC: 05/20/1999 17:34 PHYS: IBDAH, JAMAL A.

AMYLAASE *214 [30-122] U/L

COMPREHENSIVE METABO

SODIUM 138 [135-145] MEQ/L

POTASSIUM *3.3 [3.5-5.0] MEQ/L

CHLORIDE *91 [95.0-106] MEQ/L

CO2 *32 [22.0-30] MEQ/L

UREA-N *4 [8.0-24.0] MG/DL

GLUCOSE 84 [70.0-110] MG/DL

CREATININE 0.7 [0.5-1.5] MG/DL

CALCIUM 8.8 [8.5-10.5] MG/DL

PROTEIN *5.8 [6.0-8.0] G/DL

ALBUMIN *2.9 [3.2-5.0] G/DL

BILIRUBIN, TOTAL *1.4 [0.1-1.2] MG/DL

ALK P'TASE 89 [30.0-110] U/L

SGOT (AST) *50 [5.0-35.0] U/L

LIPASE *37 [4-24] U/DL

COMPLETE BLOOD COUNT

WHITE BLOOD COUNT 7.1 [4.8-10.8] X1000

RED BLOOD COUNT *4.10 [4.7-6.1] X1,000,000

HEMOGLOBIN *11.9 [14.0-18.0] G/DL

CALLED

TO LONG 052099 1800.

HEMATOCRIT *34.7 [42.0-52.0] %

CALLED

TO LONG 052099 1800.

MEAN CELL VOLUME 84.7 [80.0-94.0] FL

CV OF MCV 13.8 [11.5-14.5] %

PLATELET COUNT 199 [160-360] X1000

F20018 COLL: 05/21/1999 07:10 REC: 05/21/1999 07:49 PHYS: IBDAH, JAMAL A.

COMPREHENSIVE METABO

SODIUM 139 [135-145] MEQ/L

POTASSIUM 3.7 [3.5-5.0] MEQ/L

CHLORIDE *92 [95.0-106] MEQ/L

CO2 28 [22.0-30] MEQ/L

UREA-N 9 [8.0-24.0] MG/DL

GLUCOSE 70 [70.0-110] MG/DL

CREATININE 0.7 [0.5-1.5] MG/DL

CALCIUM 8.6 [8.5-10.5] MG/DL

PROTEIN 6.0 [6.0-8.0] G/DL

ALBUMIN *3.1 [3.2-5.0] G/DL

NATION, MARVIN KURT

CONTINUED

PAGE1

Winston-Salem, N.C. 27157
(336) 716-2661 (LAB)

PHYSICIAN COPY

Wake Forest University
Baptist Medical Center

09-098708 (11/97)

05/27/1999
15:04

NC BAPTIST HOSPITAL

LABORATORY RESULTS
PAGE 2

NAME: NATION, MARVIN KURT

*** PATIENT DISCHARGED ***

H# : 1457143

LOC: 4W

ROOM: 0481A

AGE: 33Y SEX: M

ACCT: 010381979139 DR: IBDAH, JAMAL A. 28640/GIN

Winston-Salem, N.C. 27157
(336) 716-2661 (LAB)

F20018 COLL: 05/21/1999 07:10 REC: 05/21/1999 07:49 PHYS: IBDAH, JAMAL A.

COMPREHENSIVE METABO

(CONTINUED)

BILIRUBIN, TOTAL	1.1	[0.1-1.2]	MG/DL
ALK P'TASE	82	[30.0-110]	U/L
SGOT (AST)	30	[5.0-35.0]	U/L

COMPLETE BLOOD COUNT

WHITE BLOOD COUNT	7.7	[4.8-10.8]	X1000
RED BLOOD COUNT	*4.05	[4.7-6.1]	X1,000,000
HEMOGLOBIN	*11.8	[14.0-18.0]	G/DL
HEMATOCRIT	*34.1	[42.0-52.0]	%
MEAN CELL VOLUME	84.1	[80.0-94.0]	FL
CV OF MCV	13.5	[11.5-14.5]	%
PLATELET COUNT	175	[160-360]	X1000

S16093 COLL: 05/22/1999 07:25 REC: 05/22/1999 08:13 PHYS: IBDAH, JAMAL A.

COMPREHENSIVE METABO

SODIUM	135	[135-145]	MEQ/L
POTASSIUM	4.2	[3.5-5.0]	MEQ/L
CHLORIDE	96	[95.0-106]	MEQ/L
CO2	27	[22.0-30]	MEQ/L
UREA-N	12	[8.0-24.0]	MG/DL
GLUCOSE	*60	[70.0-110]	MG/DL
CREATININE	0.7	[0.5-1.5]	MG/DL
CALCIUM	8.7	[8.5-10.5]	MG/DL
PROTEIN	*5.8	[6.0-8.0]	G/DL
ALBUMIN	*3.1	[3.2-5.0]	G/DL
BILIRUBIN, TOTAL	1.0	[0.1-1.2]	MG/DL
ALK P'TASE	85	[30.0-110]	U/L
SGOT (AST)	19	[5.0-35.0]	U/L

COMPLETE BLOOD COUNT

WHITE BLOOD COUNT	7.8	[4.8-10.8]	X1000
RED BLOOD COUNT	*4.14	[4.7-6.1]	X1,000,000
HEMOGLOBIN	*12.1	[14.0-18.0]	G/DL
HEMATOCRIT	*34.8	[42.0-52.0]	%
MEAN CELL VOLUME	83.8	[80.0-94.0]	FL
CV OF MCV	13.8	[11.5-14.5]	%
PLATELET COUNT	206	[160-360]	X1000

X62083 COLL: 05/23/1999 07:05 REC: 05/23/1999 08:18 PHYS: IBDAH, JAMAL A.

COMPREHENSIVE METABO

NATION, MARVIN KURT

CONTINUED

PAGE2

Wake Forest University
Baptist Medical Center

02-080708 (11/97)

05/27/1999
15:04

NC BAPTIST HOSPITAL

LABORATORY RESULTS
PAGE 3

NAME: NATION, MARVIN KURT

*** PATIENT DISCHARGED ***

H# : 1457143

LOC: 4W

ROOM: 0481A

AGE: 33Y SEX:M

ACCT: 010381979139 DR: IBDAH, JAMAL A. 28640/GIN

X62083 COLL: 05/23/1999 07:05 REC: 05/23/1999 08:18 PHYS: IBDAH, JAMAL A.

COMPREHENSIVE METABO

(CONTINUED)

SODIUM	137	[135-145]	MEQ/L
POTASSIUM	3.5	[3.5-5.0]	MEQ/L
CHLORIDE	*92	[95.0-106]	MEQ/L
CO2	*31	[22.0-30]	MEQ/L
UREA-N	*6	[8.0-24.0]	MG/DL
GLUCOSE	102	[70.0-110]	MG/DL
CREATININE	0.8	[0.5-1.5]	MG/DL
CALCIUM	9.0	[8.5-10.5]	MG/DL
PROTEIN	*5.9	[6.0-8.0]	G/DL
ALBUMIN	3.2	[3.2-5.0]	G/DL
BILIRUBIN, TOTAL	0.8	[0.1-1.2]	MG/DL
ALK P'TASE	98	[30.0-110]	U/L
SGOT(AST)	20	[5.0-35.0]	U/L

COMPLETE BLOOD COUNT

WHITE BLOOD COUNT	6.0	[4.8-10.8]	X1000
RED BLOOD COUNT	*3.99	[4.7-6.1]	X1,000,000
HEMOGLOBIN	*11.6	[14.0-18.0]	G/DL
HEMATOCRIT	*33.8	[42.0-52.0]	%
MEAN CELL VOLUME	84.5	[80.0-94.0]	FL
CV OF MCV	13.5	[11.5-14.5]	%
PLATELET COUNT	203	[160-360]	X1000

Winston-Salem, N.C. 27157
(336) 716-2661 (LAB)Wake Forest University
Baptist Medical Center

09-088708 (11/97)

NATION, MARVIN KURT

END OF REPORT

PAGE3

RADIOLOGY REPORT

FINAL REPORT

PHYSICIAN COPY FOR IBDAH, JAMAL AHMAD

THE MEDICAL CENTER

DEPARTMENT OF RADIOLOGY

PATIENT NAME: NATION, MARVIN KURT
REQUISITION : 3861555
DATE DONE : 05/24/99
REFERRING DR: IBDAH, JAMAL AHMAD
RADIOLOGIST : GELFAND, DAVID

UNIT #: 1457143
LOCATION: 0481A
DATE READ: 05/26/99
ORDERING DR: IBDAH, JAMAL AHMAD
RESIDENT DR: POTTER, JEFFREY

ADM DX: PANCREATITIS

INDICATIONS: ERCP

INDICATIONS:

ERCP, 5/24/99 AT 1415 HOURS:

INDICATION:

ERCP.

FINDINGS:

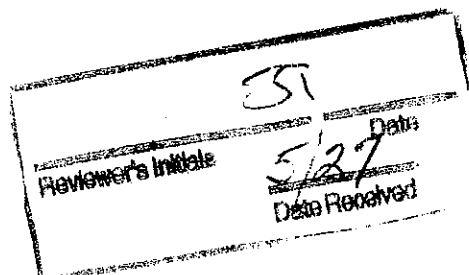
IMAGES 1 THROUGH 8 SHOW INJECTION OF A NORMAL BILIARY TREE WITHOUT SIGNS OF DILATATION OR CALCULI. FILMS 9 THROUGH 12 SHOW INJECTION OF A DILATED PANCREATIC DUCT WITH AN APPEARANCE CONSISTENT WITH PANCREATITIS.

FILM 13 SHOWS STENT PLACEMENT WITHIN THE DILATED PANCREATIC DUCT.

I HAVE PERSONALLY REVIEWED AND INTERPRETED THIS IMAGE/IMAGES.

RESIDENT DR: POTTER, JEFFREY
INTERPRETING DR: GELFAND, DAVID
SIGNED BY DR: GELFAND, DAVID

DATE AND TIME: 05/26/99 16:04



MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

DISCHARGE SUMMARY

NATION, MARVIN KURT

NCBH # 145-71-43

Jamal Ahmad Ibdah, M.D.

Admitted 05/20/1999

Discharged 05/25/1999

DISCHARGE DIAGNOSIS:

1. Distal common bile duct stenosis.
2. Chronic pancreatitis.
3. Pancreatic pseudocyst which was communicating with the main pancreatic duct.
4. History of alcohol abuse.
5. History of gastritis.

ADMISSION DIAGNOSIS:

1. Abdominal pain.
2. Persistent nausea and vomiting.
3. Pancreatitis with pseudocyst.
4. History of alcohol abuse.
5. History of gastritis.

DISCHARGE MEDICATIONS:

1. Creon two tablets 15 minutes before each meal.
2. Demerol 100 mgs p.o. every four hours as needed for pain.
3. Phenergan 25 mgs every four hours as needed for nausea.

PROCEDURE(S) PERFORMED:

1. ERCP with stent placement in the pancreatic duct.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old white male with a history of pancreatitis and pseudocyst, a history of alcohol abuse and gastritis who was transferred from Catawba Memorial Hospital with acute abdominal pain associated with nausea and vomiting. The patient reported a history of pancreatitis which was diagnosed two years ago but states that he has had not any alcohol since November of 1998. He was seen at Wake Forest University Baptist Medical Center emergency department on 5/13/99 with abdominal pain, nausea and vomiting. He was discharged home at that time after being given pain medications and IV fluids. His symptoms did not resolve and therefore he presented to the outside hospital on 5/16/99 for pain management and fluids. The patient was then transferred here for further evaluation.

HOSPITAL COURSE: The patient was admitted to a general medicine gastroenterology service. He was given pain medicines and antiemetics. He was scheduled to undergo endoscopic ERCP the day after admission. However attempts to sedate him for the procedure were unsuccessful on Friday, 5/21/99. The procedure was then delayed until 5/24/99 at which time he underwent ERCP. This revealed chronic pancreatitis. A pancreatic pseudocyst which communicate with the main pancreatic duct and a distal common bile duct stenosis secondary to the chronic pancreatitis. A 7 French 8 cm long single pigtail stent was placed in the body of the pancreas. The patient tolerated the procedure well. It is hoped that with this pancreatic duct stenosis now stented and with a pseudocyst which drains into the duct that the patient's symptoms of pain, nausea or vomiting will resolve. The patient did feel better following the procedure and was requesting food.

N.C. BAPTIST HOSPITALS, INC.
MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N C 27157

DISCHARGE SUMMARY

NATION, MARVIN KURT
NCBH # 145-71-43

He was started on a clear liquid diet and tolerated that well. He was then requesting discharge.

DISPOSITION: To home.

FOLLOW-UP: The patient should follow up with his primary care physician in one to two weeks.

Bryan H Fuller, MD
House Officer

Jamal Ahmad Ibdah, M.D.
Attending Physician
Gastroenterology

BHF/ana D 05/25/1999 T 05/25/1999 Doc# 614689 Job# 19

cc: Lawrence McClur Caldwell, MD
24 S Brady Street
PO Box 849
Newton, NC 28658

Dana Chambers-Kelleff, MD
212 29th Avenue
Hickory, NC 28601

James Comer Gaither, M.D.
Catawba Valley Int Med
3411 Graystone Place
Conover, NC 28613

Russell Howerton, MD

Jamal Ahmad Ibdah, M.D.

**Wake Forest University Baptist Medical Center
ERCP Report**

Todays Date: 5/21/1999

Patient Name: Marvin Nation

Paient ID#: 1457143

Exam Date: 05/21/1999

Attending Physician: Dr Ben Pineau

Referring Physician: Dr Jamal Ibdah

DR

INTRODUCTION:

33 year old male patient presents for an elective inpatient ERCP. The indication for this procedure was to evaluate known chronic pancreatitis

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

The patient's cardiac status, blood pressure, pulse and pulse oximetry was monitored. An intravenous line was inserted. The patient has been NPO since midnight

MEDICATIONS:

Demerol 300 mg IV, Versed 10 mg IV, Droperidol 7.5 mg IV

PROCEDURE:

The endoscope was passed with great difficulty by manual insertion to the esophagus but patient was very combative and the scope was quickly withdrawn for fear of trauma to the scope and to the patient.

COMPLICATIONS:

There were no complications associated with the study.

IMPRESSION:

1 Failed attempt at ERCP due to inability to sedate. (Uncoded).

RECOMMENDATION:

- Repeat ERCP in 2 days with general anesthesia
- Keep patient NPO, consider PPN.
- Cipro 400 mg IV on call to ERCP, scheduled for 1pm on Monday with GA in Specials Radiology

(uncoded): ESOPHAGOSCOPY.



Dr. Ben Pineau

5/21/1999

N.C. BAPTIST HOSPITALS, INC.

MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

HISTORY and PHYSICAL

NATION, MARVIN KURT

NCBH # 145-71-43

Jamal Ahmad Ibdah, M.D.

Admitted 05/20/1999

Room 4W 0481

REFERRING PHYSICIAN: Dr. Chambers, Hickory, North Carolina.

CHIEF COMPLAINT: Abdominal pain/nausea and vomiting.

HISTORY OF PRESENT ILLNESS: The patient is a 33-year-old white male with a past medical history significant for pancreatitis with pseudocyst, (2/99) presents on transfer to Catawba Memorial Hospital with acute abdominal pain and nausea and vomiting. The patient reports pancreatitis diagnosed approximately two years ago significant for alcohol abuse but has not had any alcohol since November of 1998. The patient was seen at North Carolina Baptist Hospital Emergency Department last Wednesday, 5/13/99 for severe abdominal pain, nausea and vomiting with "green vomitus" and an amylase of 342 by lipase. The patient was subsequently discharged to home after using intravenous fluids and given pain medicines. The patient's symptoms did not resolve. Therefore approximately three days later she presented and was admitted to Catawba on 5/16/99 for pain management and fluids. The patient does report his abdominal pain may be slightly different than usual in that it hurts in the bilateral lower quadrants this time as well as the diffuse epigastric pain. The patient denies any fever or chills or diarrhea, he does report that his urine is darker than usual and has not eaten in approximately 10 days secondary to nausea and vomiting. The patient reports no blood in his stool or vomitus and describes his vomitus as very dark green in nature.

Of note, the patient had a CT of the abdomen at Forsyth Memorial Hospital and noted the following:

1. Distention of the stomach and proximal duodenum.
2. Pancreatitis with a 30 cm fluid collection in the left pancreas head which had also been noted on previous CT of the abdomen in February and March of 1999.
3. Fatty liver.
4. Ascites.
5. Bibasilar lung scarring, right and anterolateral dorsiflexion along the duodenum.

The patient was seen on 4/21/99 by Dr. Howerton on referral in the General Surgery Clinic for possible drainage of the pseudocyst. Dr. Howerton recommended an ERCP which the patient was referred to Dr. Ben Ineaux.

PAST MEDICAL HISTORY:

1. Pancreatitis with a pseudocyst (3 cm) in the head of the pancreas.
2. Alcohol abuse.
3. Gastritis.

PAST SURGICAL HISTORY:

1. Partial gastrectomy in 1994 in California secondary to peptic ulcer disease.
2. Right inguinal hernia repair.

N.C. BAPTIST HOSPITALS, INC.

MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43

HISTORY and PHYSICAL

ALLERGIES: No known drug allergies.

MEDICATIONS:

1. Percocet prn. (up to 15 tablets a day).
2. Creon two tablets before each meal.

SOCIAL HISTORY: The patient lives in Hickory, North Carolina with his wife for two years and three children and the patient reports drinking alcohol heavily in the past but quit in November of 1998. The patient smokes approximately one pack per day and has for four years. The patient denies any IV drug abuse. The patient works at Motor Line where he moves and loads furniture.

FAMILY HISTORY: Father and mother are alive and in good health. She has four siblings who are in good health except for one brother who has stomach problems.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 118/70, respirations 20, temperature 97.8. The patient is sitting at 96 percent on room air.

GENERAL: This is a pleasant male in no acute distress. He had a green material talking.

NECK: Supple without evidence of bruits, thyromegaly or lymphadenopathy.

HEENT: Normocephalic, atraumatic. Pupils are equal and reactive to light and accommodation and extraocular movements are intact. Mucous membranes are moist. There is no erythema or exudate noted.

LUNGS: Clear to auscultation bilaterally.

CARDIOVASCULAR: Regular rate and rhythm without murmurs, rubs or gallops.

ABDOMEN: There is an old well-healed midline scar with a three cm umbilical hernia with hypoactive bowel sounds, tense, no rebound, mild guarding, tender in the epigastric area as well as left lower quadrant. No masses or hepatosplenomegaly present.

EXTREMITIES: There was 2+ dorsalis pedis and femoral pulses are noted bilaterally. No clubbing, cyanosis or edema.

NEUROLOGICAL EXAMINATION: Cranial nerves II-XII intact. No focal deficits.

LABS: At the outside hospital on 5/16, urinalysis showed 1+ protein, 3+ ketones and 1+ bilirubin. PT was 12.9 and INR was 1.2, PTT 26. The patient's amylase was 322 on 5/16/99. On 5/18, amylase had dropped to 183 and lipase on 5/18 was 584. The patient's sodium was 154, potassium 3.6, BUN 106, creatinine 0.8, glucose 108, white cell count 8.9 which was previously on admission of 5/16/99 noted to be 13.3. Hemoglobin was 12.6, hematocrit 37.4, platelet count 208. The alkaline phosphatase was 100, SGOT 14, total protein 7.6, albumin 4.2, calcium 9.5. CT of the abdomen was above. Please note after family history and review of systems were negative, otherwise as noted above.

ASSESSMENT AND PLAN: This is a 33-year-old white male with pancreatitis, (chronic and pseudocyst (3 cm) presented upon transfer from Catawba secondary to continued nausea and vomiting and abdominal pain. Admit to General Medicine C.

N.C. BAPTIST HOSPITALS, INC.

MEDICAL CENTER BOULEVARD
WINSTON-SALEM, N.C. 27157

NATION, MARVIN KURT
NCBH # 145-71-43

HISTORY and PHYSICAL

1. GI. The patient had chronic pancreatitis presents with an ERCP in the a.m. The patient will be checked n.p.o. after midnight for the ERCP.

2. Check an amylase and a lipase now. The patient was noted to be afebrile with a white cell count of 13.2 upon admission to the outside hospital. We will monitor CBC without any kind of pancreatic abscess or rupture. The patient will be managed with Demerol for pain control. The patient will be given intravenous fluids at approximately 75 cc. an hour as well hydrated at the outside hospital.

Timothy Dibble, MD
House Officer

Jamal Ahmad Ibdah, M.D.
Attending Physician
Gastroenterology

/emw D 05/20/1999 T 05/20/1999 Doc# 612344 Job# 97

cc: Jamal Ahmad Ibdah, M.D.

Wake Forest University
Baptist Medical Center

Winston-Salem, N.C. 27157
(336) 716-2661 (LAB)

ADMITTED: 05/05/1999 ACCT#: 010381979124

LOC: WGIN 33Y M # 1457143 NATION, MARVIN KURT
DR: PINEAU, BENOIT C 26710/ GIN
PHYSICIAN COPY FOR DR: PINEAU, BENOIT C

TEST: PH PO2 PCO2 HCO3 BASE EXCESS O2 SAT FIO2 TEMP COMMENT
UNITS: mm Hg mm Hg mmol/L mmol/L % %
PO-HI: 7.350- 85-90 35-45 22-26 85-98

05/13 + 2044 7.610* 79* 19.4* 20* 1 98 NO ENTRY NO ENTRY POC

*Long
Please find
check for I order
with did n-*

Reviewer's initials

5/17/99
Date Received

---FOOTNOTES---
POC POINT-OF-CARE TESTING

**Wake Forest University Baptist Medical Center
ERCP Report**

Todays Date: 5/24/1999

Patient Name: Marvin Nation

Paient ID#: 1457143

Exam Date: 05/24/1999

Attending Physician: Dr. Ben Pineau

Referring Physician: Dr. Jamal Ibdah

INTRODUCTION:

33 year old male patient presents for an elective inpatient ERCP. The indication for this procedure was recurrent pancreatitis related to h/o ETOH use with a known pseudocyst on CT scan.

CONSENT:

The benefits, risks, and alternatives to the procedure were discussed and informed consent was obtained from the patient.

PREPARATION:

The patient has been NPO since midnight an intravenous line was inserted. The patient's cardiac status, blood pressure, pulse and pulse oximetry was monitored

MEDICATIONS: General Anesthesia

PROCEDURE:

The endoscope was passed with ease under direct visualization to the 2nd portion of the duodenum. The study was performed with a TJF-100 Olympus video duodenoscope.

EXAMINATION:

STOMACH: There was evidence of Billroth I anastomosis. There was food residue and retained secretions and bile present in the stomach.

DUODENUM: The duodenum appeared normal

MAJOR PAPILLA: The major papilla appeared normal

ERP: There was a 5 mm high grade stricture in the distal main pancreatic duct. The main pancreatic duct in the head of the pancreas was dilated to 12 mm. It was irregular in contour with ectatic side branches. There was a 1.5 cm x 2 cm cyst in the head of the pancreas communicating with the main pancreatic duct.

ERC: There was a smooth stenosis of the distal CBD in the intra-pancreatic portion measuring 10 mm. The remaining common bile duct, common hepatic duct, right and left hepatic ducts, intrahepatic ducts, cystic duct and gallbladder were normal.

THERAPY:

Without a prior sphincterotomy, an attempt to place 7 Fr 8 cm long single pigtail stent in the body of the pancreas was made. The procedure was successful. At completion of placement the stent position was ideal. The proximal end lay within the body of the pancreas. There was prompt drainage of clear pancreatic juice. A precut papillotomy was performed with a 5 Fr single-lumen needle-knife papillotome over the pancreatic stent. There were no immediate complications.

IMPRESSION:

- 1 Chronic pancreatitis (Cambridge class IV).
- 2 Pancreatic pseudocyst communicating with main pancreatic duct
- 3 Distal CBD stenosis due to #1.

RECOMMENDATION:

Repeat ERCP with stent change in 8 weeks. If endoscopic therapy fails would recommend lateral pancreatojejunostomy

**Wake Forest University Baptist Medical Center
ERCP Report**

Todays Date: 5/24/1999

Patient Name: Marvin Nation

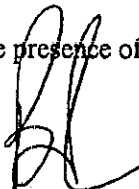
Paient ID#: 1457143

Exam Date: 05/24/1999

Attending Physician: Dr. Ben Pineau

Referring Physician: Dr. Jamal Ibdah

The procedure was performed by Rajesh Gupta, MD in the presence of Ben Pineau, MD who was present for the entire viewing portion of the procedure.



Dr. Ben Pineau

5/24/1999

RADIOLOGY REPORT

FINAL REPORT

PHYSICIAN COPY FOR PINEAU, BENOIT C

THE MEDICAL CENTER

DEPARTMENT OF RADIOLOGY

PATIENT NAME: NATION, MARVIN KURT

UNIT #: 1457143

REQUISITION : 3657232

LOCATION: WGIN

DATE DONE : 05/06/99

DATE READ: 05/06/99

REFERRING DR: PINEAU, BENOIT C

ORDERING DR: PINEAU, BENOIT C

RADIOLOGIST : BECHTOLD, ROBERT

RESIDENT DR: ANTHONY, EVELYN Y.

ADM DX: NPV

0220 IDX VISIT # 02627178

INDICATIONS: AND PELVIC WITH CONTRAST IV, ?CHRONIC PANCREATIS

INDICATIONS:

CT OF THE ABDOMEN AND PELVIS, 5/6/99:

HISTORY:

33 YEAR-OLD MALE WITH PANCREATITIS.

TECHNIQUE:

7 MM THICK SECTIONS WERE TAKEN USING SPIRAL TECHNIQUE THROUGH THE ABDOMEN BOTH BEFORE AND AFTER POWER INJECTION OF NON-IONIC IV CONTRAST MATERIAL.

FINDINGS:

LOWER CHEST:

THE PATIENT HAS A LEFT LOWER LOBE SCAR.

ABDOMEN:

THE PANCREAS HAS DEVELOPED MULTIPLE SIGNS SUGGESTING PANCREATITIS. THE PANCREAS IS ENLARGED, AND THE PERIPANCREATIC SOFT TISSUE PLANES ARE POORLY DEFINED. THE PATIENT HAS DEVELOPED A LOW DENSITY LESION IN THE CENTER OF THE HEAD OF THE PANCREAS, MEASURING ABOUT 2 X 1.7 CM ON SERIES 3 IMAGE 76. THIS HAS WELL DEFINED MARGINS. THIS COULD REPRESENT A PSEUDOCYST IN THE HEAD OF THE PANCREAS ALTHOUGH TECHNICALLY SPEAKING, THE DIFFERENTIAL DIAGNOSIS INCLUDES CYSTIC NEOPLASM OF THE PANCREAS. THERE IS ANOTHER, OBLONG, INFRAPANCREATIC AND PREDUODENAL FLUID COLLECTION, APPEARING SIMILAR, AND MEASURING 5.7 X 1.2 CM ON SERIES 3 IMAGE 29. THIS IS THOUGHT TO REPRESENT ANOTHER PSEUDOCYST. THE PANCREATIC DUCT IS DISTENDED, MEASURING AT LEAST 4 MM IN DIAMETER, AND THE PATIENT HAS TYPICAL FINDINGS OF INFLAMMATORY REACTION IN THE FAT OF THE ANTERIOR PARARENAL SPACE, AS WELL AS THICKENING OF THE ANTERIOR RENAL FASCIA, BILATERALLY, BUT ESPECIALLY ON THE RIGHT.

THERE IS A HEPATODUODENAL LIGAMENT LYMPH NODE MEASURING 1.3 X 0.8 CM ON IMAGE 20 OF SERIES 3, COMPATIBLE WITH AN INFLAMMATORY LYMPH NODE.

THE PATIENT'S GALLBLADDER IS DISTENDED, AND THERE IS A MINIMAL DEGREE OF INTRAHEPATIC BILIARY DILATATION, ALL MOST LIKELY DUE TO THE MASS EFFECT ON THE DISTAL COMMON BILE DUCT BY THE PANCREATITIS.

THE PATIENT HAS UNDERGONE PREVIOUS SURGERY AT THE GASTROESOPHAGEAL JUNCTION.

THE PATIENT HAS AN ACCESSORY SPLEEN.

NO FOCAL LIVER LESION. THE KIDNEYS ARE WITHIN NORMAL LIMITS. THE ADRENAL GLANDS ARE NORMAL. THERE IS NO ASCITES.

PELVIS:

NO SIGNIFICANT ABNORMALITY. PELVIC RETROPERITONEUM IS NORMAL. NO ASCITES. NO PELVIC MASSES.

CONCLUSION:

1. PANCREATITIS, WITH AT LEAST TWO CYSTIC LESIONS, MOST LIKELY REPRESENTING PSEUDOCYSTS, AND SECONDARY PANCREATIC AND BILIARY DUCT DILATATION. SURROUNDING INFLAMMATORY INTERSTITIAL REACTION AND HEPATODUODENAL LIGAMENT INFLAMMATORY LYMPH NODE.

RADIOLOGY REPORT

FINAL REPORT

PHYSICIAN COPY FOR PINEAU, BENOIT C

THE MEDICAL CENTER

DEPARTMENT OF RADIOLOGY

PATIENT NAME: NATION, MARVIN KURT

UNIT #: 1457143

REQUISITION : 3657232

LOCATION: WGIN

DATE DONE : 05/06/99

DATE READ: 05/06/99

REFERRING DR: PINEAU, BENOIT C

ORDERING DR: PINEAU, BENOIT C

RADIOLOGIST : BECHTOLD, ROBERT

RESIDENT DR: ANTHONY, EVELYN Y.

SECONDARY DISTENDED GALLBLADDER AND INTRAHEPATIC DUCT DILATATION.

2. STATUS POST SURGERY AT THE GASTROESOPHAGEAL JUNCTION.

I HAVE PERSONALLY REVIEWED AND INTERPRETED THIS IMAGE/IMAGES.

RESIDENT DR: ANTHONY, EVELYN Y.

INTERPRETING DR: BECHTOLD, ROBERT

SIGNED BY DR: BECHTOLD, ROBERT

DATE AND TIME: 05/06/99 16:15

Reviewer's initials		Date
5/7		
Date Reviewed		



Wake Forest University Baptist

Department of General Surgery

Telephone: (336) 716-4241

Fax: (336) 716-9758

Office Visit
General Surgery
NATION, MARVIN KURT
NCBH# 1457143
Visit Date: 04/21/1999

ICD 9: 577.1

CPT: 99203

Mr. Nations is a 33-year-old male referred from Drs. Caldwell and Chambers for further evaluation and management of probable chronic pancreatitis. He has had a history of multiple hospitalizations for intense epigastric pain radiating through to his back associated with the inability to eat and nausea. He has had a history of chronic alcohol abuse but has refrained from alcohol for the past 3-4 months. He now has pain between episodes and is currently on Tylox and/or Percocet. Vicodin he has recently received has not managed his pain. On his admission to Catawba Memorial Hospital in February he had a CT scan of his abdomen which revealed a 3 cm cystic mass in the head of the pancreas thought likely to be pseudocyst. He had an enlargement in the uncinate process of the pancreas with dilatation of the pancreatic duct. There was no biliary ductal dilatation. He had some resolution of his problem at that time and was discharged home. However, upon re-admission in March he had a repeat CT scan which revealed a stable 3 cm cystic mass and dilatation of the pancreatic duct without significant change. There was an increasing induration in the right perirenal space but no other significant changes. He has been taking Zantac as well as Creon in addition to his pain medication. Of note, he had an apparent subtotal gastrectomy in 1993 or 1994 in San Diego for peptic ulcer disease. He has not been jaundice although apparently past admissions have shown some mild elevation and liver function studies. At present time laboratory values from 4/12/99 revealed a normal white blood cell count and hematocrit. He underwent an endoscopy which showed severe gastritis and a subtotal gastrectomy. He apparently has had an ultrasound of the gallbladder and Helicobacter pylori testing although these results are not available to me today nor his CT scans. It does not appear that he had an ERCP in the past.

By physical examination he is somewhat thin but not cachectic. He has a soft, nondistended abdomen. There is mild epigastric tenderness but no clear mass effect. His social history reveals him to be married and working as a truck loader. His past medical history reveals a hernia repair in the past as well. He smokes one pack per day and takes no other medicines than what is noted above. He in the past has used crack cocaine. His family history reveals his mother and father are both alive and well as well as four siblings without known disease. His review of systems reveals a normal cardiovascular review of system without shortness of breath or chest pain. His pulmonary review of systems reveals no shortness of breath and no associated complications to smoking. He does not have any renal difficulties. Psychiatric history reveals a crack addiction and depression as well as generalized anxiety. I have had a discussion with him today about the nature of chronic pancreatitis and the various options including the main stay of medical management as well as nerve block aid and surgical therapy both resection and drainage. Given that he is not currently diabetic I do not believe resection therapy is likely to be appropriate and I cannot clearly distinguish today whether or not drainage therapy would be appropriate.

Wake Forest University School of Medicine at the Bowman Gray Campus
The North Carolina Baptist Hospitals, Incorporated

Medical Center Boulevard • Winston-Salem, North Carolina 27157-1095

Nation, Marvin Kurt

2 of 2

As well I cannot comment further on his pseudocyst until I have obtained the films. I believe an ERCP will be useful in this man and I will make arrangements for him to see Dr. Ben Pineau here for

ADMITTED: 05/05/1999 ACCT#: 010381979124

LOC: WGIN
DR: PINEAU, BENOIT C 26710/ GIN
PHYSICIAN COPY FOR DR: PINEAU, BENOIT C
33Y M # 1457143 NATION, MARVIN KURT

TEST: PLT HB HCT RBC MCV RDW WBC SEG BAND CBC AND DIFFERENTIAL
UNITS: THOU G/DL % MIL FL INDEX THOU THOU THOU THOU THOU THOU THOU THOU
LO-HI: 160-14.0-42.0- 4.7- 80.0- 11.5- 4.8- 1.6- 0.0- 1.0- 0.16- 0.0- 0.0-
360 18.0 52.0 6.1 94.0 14.5 10.8 7.3 0.2 5.1 0.9 0.5 0.3
05/05 + 1141 219 14.4 40.7* 4.86 83.7 13.5 10.3

TEST: PT PT FIBRINOGEN
UNITS: SEC INR MG/DL
LO-HI: 10.8- 180-363
05/05 + 1141 12.4 1.00 260

TEST: COLOR CLARITY S.G. PH ALB GLUC KETO BILI UBG BLOOD NITR LEUK
UNITS: MG/DL MG/DL MG/DL MG/DL EU/DL
LO-HI: 1.005- 5.5- 1.025 6.5
05/05 + 1141 1.005- 5.5- 1.025 6.5

TEST: NA K CL CO2 GLUC (B) UN GREAT URIC CA PHOS CHOL PROT ALB TBILI DBILI ALK-P GOT LDH IRON
UNITS: MEQ/L MEQ/L MEQ/L MG/DL MG/DL MG/DL MG/DL MG/DL MG/DL G/DL G/DL MG/DL MG/DL U/L U/L U/L MCG/DL
LO-HI: 135- 3.5- 95.0- 22.0- 70.0- 8.0- 0.5- 2.5- 8.5- 2.5- 120- 6.0- 3.2- 0.1- 0.0- 30.0- 5.0- 90.0- 40.0-
145 5.0 106 30 110 24.0 1.5 8.0 10.5 4.5 260 8.0 5.0 1.2 0.4 110 35.0 250 160
05/05 + 1141 137 3.7 94* 29 108 5* 0.8 9.5 7.5 4.4 0.5 104 22

TEST: AMYLASE LIPASE
UNITS: U/L U/DL
LO-HI: 0-280 4-240
05/05 + 1141 333* 31*

05/05 + 1141 LIPID PROFILE
CHOLESTEROL 119 1<2001 MG/DL
TRIGLYCERIDE 137 1<3001 MG/DL

<<RESULTS CONTINUED ON NEXT PAGE>>

Fluorometer's Initials
5-6-97
Date Rec'd

CORRECTIONAL MEDICAL SERVICES
INFIRMARY ADMISSION RECORD

NAME: <u>Nation, Mawr</u>	ID#: <u>141669</u>	RACE: <u>White</u>	DOB: <u>[REDACTED]</u>
---------------------------	--------------------	--------------------	------------------------

ADMISSION TO BE COMPLETED BY PERSON RECEIVING PATIENT IN INFIRMARY

Date: 8/2/98 Time: 16:05 From: [REDACTED]Method: Ambulatory ☐ Wheelchair ☐ Stretcher ☐ Admitting M D [REDACTED]Admitting Diagnosis: [REDACTED] Admitting M D notified: [REDACTED] A M 16:05 P MAdmitting Orders: ☐ Yes ☐ No Medical Record ☐ Yes ☐ No Transfer Medical Information: ☐ Yes ☐ NoVITAL SIGNS: Time: 16:05 Wt [REDACTED] BP 132/84 Pulse 84 Resp 20 Temp 97.5PPD: Date: 8/24/98 Results: 8/26/98 DMUKnown Allergies: ☒ None If Yes, list and describe reaction:

Food

Drug NKDA

MEDICATIONS Patient is currently taking (include over-the-counter medications)

NAME	DOSE/TIME/LAST DOSE	NAME	DOSE/TIME/LAST DOSE
<u>NO MEDS</u>			

EMOTIONAL STATUS: ☐ Relaxed ☐ Cooperative ☐ Withdrawn ☐ Openly anxious ☐ Uncooperative

IMPAIRMENTS:

Hearing: ☐ Adequate Decreased Rt ☐ Lt ☐ Deaf Rt ☐ Lt ☐ Hearing Aid Rt ☐ Lt ☐Visient: ☒ Adequate Decreased Rt ☐ Lt ☐ Glasses ☐ Contacts ☐ Cataracts ☐ Artificial Eye ☐ Glaucoma ☐Communication: Language English ☒ Other [REDACTED] Interpreter [REDACTED]

Social History:

Drug or Alcohol use: 6 to 8 yrs agoEducational Level: High School gradSmoking: 1 pack per day

SKIN ASSESSMENT:

Presence of skin lesions ☒ No ☐ Yes

If Yes, describe on Skin Assessment form

Skin color: pink Skin temperature: ☐ Warm ☐ Dry ☐ Cool ☐ MoistEdema 0 Describe:Fingernails: Color pink Condition intact / goodToenails: Color pink Condition intact / good

NUTRITION ASSESSMENT

Last intake: Food 8/2/98 AM (Date/Time) Fluid 8/2/98 PM (Date/Time)Recent weight changes (reason) [REDACTED] ☐ Increase ☐ Decrease☐ Difficulty in swallowing☐ Special DietFeeding Tube ☐ Yes ☐ No Type [REDACTED]

ELIMINATION ASSESSMENT

Last Bowel Movement 8/1/98 Constipation ☐ No ☐ Yes Diarrhea ☒ No ☐ YesUrine: Frequency [REDACTED] Urgency ☐ No ☐ Yes Discharge ☐ No ☐ Yes Burning ☐ No ☐ Yes

POTENTIAL FOR INJURY:

Steady on feet: ☒ Yes ☐ No Unsteady on feet ☐ Yes ☐ No Aids to mobility: ☐ NA ☐ Cane ☐ Walker ☐ Crutches

Wheelchair Prosthesis

Recent falls: ☒ No ☐ YesSignature [REDACTED]Date [REDACTED]

CORRECTIONAL MEDICAL SERVICES

INTERDISCIPLINARY PROGRESS NOTES

Patient Name Nation, Marvin I.D. # 141669 Institution Kilby

DATE	TIME	NOTES	SIGNATURE
9/4/98		<p>③ 32 yo W.O. to Hx of pancreatitis in the past, presented to severe abd. pain, was NPO & IVF started to pain meds, now the pain is much improved, took some H₂O by mouth yesterday & any problem.</p> <p>④ Lungs - clear Heart RRR 5 @</p> <p>Abd - soft, & mass, slight tender at epigastric area, BS present, & rebound, & guarding.</p> <p>A/P) Poss. Chronic pancreatitis - resolving, will start soft diet today, cont to IVF & Tagamet for now. Thank</p> <p>Add Pancrease.</p>	
9/7/98		<p>③ Pt is doing OK, eating well, & N/V, occasional slight abd. pain, & constipation & diarrhea.</p> <p>④ Lungs - clear Heart RRR 5 @</p> <p>Abd - soft, & tender, & mass, BS present & rebound, & guarding.</p> <p>A/P) Chronic Pancreatitis - stable now, cont as is to Pancrease before meals, release to pop. Thank</p>	

INTERDISCIPLINARY PROGRESS NOTES

Institution KCF

[illegible]

CORRECTIONAL MEDICAL SERVICES

INTERDISCIPLINARY PROGRESS NOTES

Patient Name NATION, MARVIN ID. # 141669 Institution KCF

DATE	TIME	NOTES	SIGNATURE
9/10/98	2120	S- "CAN I HAVE SOMETHING FOR PAIN." O- INMATE STANDING AT 2 IV D5 1/2 NS INFUSING @ KDCU HR IV. SITE LOOKS GOOD. NO REDNESS OR SWELLING AT SITE. TAGAMENT 300 mg IV GIVEN AS ORDERED. Resp. & COUGH, UNABORED. SKIN WARM + DRY TO TOUCH. A. ALTERATION IN COMFORT. P- Demerol 25 mg IM given in lt. hip. Tolerated well. Will continue to monitor.	R. Buckette, LPN
9/10/98	2330	S- CAN I HAVE MY IV DISCONTINUED. O- STANDING AT GATE. A- NO ACUTE DISTRESS NOTED. P- Notified Dr. AN that inmate want IV D/C. Dr. AN gave orders it's OK TO D/C IV + Tagament	R. Buckette, LPN
9/10/98	0330	S- "I need something for pain" O- Up on ward at gate A- Alteration in level of comfort. P- Will continue to monitor, Demerol 25mg IM as ordered for pain.	J. Williams RN
9-6-98	0400	S- "I'm hurting Can I get a shot" O- laying on Bed sent OX3 A- same as above P- cont Plan of Care	Chn Gln
9-6-98	1700	S- "I'm hurting CAN I HAVE SOMETHING FOR PAIN" O- Up on ward @ gate. A- Alteration in comfort. P- Demerol 25 mg given IM Will continue to monitor.	R. Buckette, LPN

DATE	TIME	NOTES	SIGNATURE
9-3-98	2400	Resting on bed & eyes closed, IV infusing S difficulty; resp easy & reg.; skin D. Will continue to monitor & document changes.	SPonyu
	0445	S. "I want my pain med." ——— O-Up making bed & going to BR. ——— A-Had juice at bed side & told inmate he is NPD. Inmate stated if he could not have juice to drink; he wanted something for pain. P-Will continue to monitor & document changes.	SPonyu SPonyu SPonyu
7/3/98	0915	S. - "Can I please have something for this pain." O. - inmate is alert, oriented x3. Speech clear & coherent. PERRA. Inmate lying in bed - HOB 1. Respirations even & unlabored. Jugular clear & EFB's. Abdomen flat. Lungs clear & upper abd. mild epigast. it Upper abdominal pain. IV infusing clear DS @ NS @ 158 gph. DS NS @ 158 gph infusing at the D area. It clear & no redness or swelling noted @ the site. Inmate MAEW in position of prone from neck to sole in bed. A. Route Pain / Altered in cry P. Give Demoral OD by DM. E. Inmate resting quietly & eye. Respirations unlabored. —————	NAN R.

CORRECTIONAL MEDICAL SERVICES

INTERDISCIPLINARY PROGRESS NOTES

Patient Name NATION, MARVINI.D. # 141669Institution KCF

DATE	TIME	NOTES	SIGNATURE
9/10/98	2120	S- "CAN I HAVE SOMETHING FOR PAIN." O- INMATE STANDING AT \bar{c} IV DS 1/2 NS INFUSING @ KOCUR IV. SITE LOOKS GOOD. NO REDNESS OR SWELLING AT SITE. TAGAMENT 300 mg IV GIVEN AS ORDERED. Resp. \bar{c} COX ET, UNABORED. SKIN WARM + DRY TO TOUCH. A- ALTERATION IN COMFORT. P- Demerol 25 mg IM given in lt. hip, TOLERATED WELL. Will CONTINUE TO MONITOR.	R. Buckette LPN
9/10/98	2130	S- CAN I HAVE MY IV DISCONTINUED. O- STANDING AT GATE. A- NO ACUTE DISTRESS NOTED. P- Notified DR. AN that inmate WANT IV D/C. DR. AN gave ORDERS IT'S OK TO D/C IV + Tagament	R. Buckette LPN
9/10/98	0330	S- "I need something for pain" O- Up on ward at gate A- Alteration in level of comfort. P- Will continue to monitor, Demerol 25mg IM as ordered for pain.	J. Williams RN
9-6-98	0108	S- "I'm hurting can I get a shot" O- laying on Bed rest OX3 A- same as above P- sent Plan of Care	Chun Gil
9-6-98	1700	S- "I'm hurting CAN I HAVE SOMETHING FOR PAIN" O- Up on ward @ gate. A- Alteration in comfort. P- Demerol 25 mg given IM, Will continue to monitor	R. Buckette LPN

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

MARVIN NATION, (AIS # 141669) *

Plaintiff, *

V. *

2:06-cv-693-ID

WILLIE AMBERS, ET AL. *

Defendants. *

AFFIDAVIT OF MICHAEL E. ROBBINS, M.D.

BEFORE ME, Betty S. Carr, a notary public in and for said County and State, personally appeared **MICHAEL E. ROBBINS, M.D.**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of his ability, information, knowledge and belief, as follows:

"My name is Michael E. Robbins. I am a medical doctor and am over twenty-one years of age. I have been a licensed physician in Alabama since 1986 and have been board certified in internal medicine since 1986. Since June of 2002, I have served as the Medical Director for Kilby Correctional Facility in Mt. Meigs, Alabama. Since November 3, 2003, my employment has been with Prison Health Services, Inc., the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates. I am personally familiar with all of the facts set forth in this Affidavit.

The Plaintiff, Marvin Nation (AIS #141669), was incarcerated as an inmate at Kilby Correctional Facility from September 26, 2004 through October 5, 2004. I am familiar with Mr. Nation and was involved with the medical services provided to him at Kilby. In addition, I have

reviewed Mr. Nation's Complaint in this action as well as his medical records (certified copies of which are being produced to the Court along with this Affidavit).

Mr. Nation was involved in an automobile accident on September 21, 2004 while working with a road crew while incarcerated at Elmore County Correctional Facility. Mr. Nation was transferred to Kilby Correctional Facility on September 26, 2004 following his discharge from Baptist Medical Center East where he had undergone an Open Reduction Internal Fixation (O.R.I.F.) procedure by Richard A. Kean, M.D. to set a left zygomatic maxillary complex (ZMC) fracture as well as left maxillary alveolar segment fracture (which was performed on September 24, 2004). Mr. Nation was housed at Kilby until October 5, 2004 when he was transferred.

I first evaluated Mr. Nation on September 26, 2004 after he was returned from surgery. At that time I noted that he was suffering from post-operative pain, but, otherwise was in no acute distress. His jaws were wired together subsequent to surgery. He displayed some facial bruising as well as a healing abrasion on his lower left leg. He was clinically stable. I subsequently admitted Mr. Nation to Kilby's infirmary for post-surgical care.

Pursuant to Dr. Kean's post-operative orders, Mr. Nation was prescribed narcotic pain relievers including Vicoden and Hydrocodone Elixir. He was also prescribed Amoxicillin, an antibiotic. To facilitate eating, Mr. Nation was placed on a soft food diet. He was allowed oral saline rinses as needed.

Mr. Nation received regular nursing evaluation while admitted to Kilby's infirmary from September 26, 2004 through October 5, 2004. I personally evaluated Mr. Nation on September 28th, September 29th, October 1st, and October 5th, 2004. Mr. Nation's condition remained stable and his plan of treatment was maintained. Mr. Nation was transferred to Dr. Kean for follow-up

evaluation on September 29, 2004 and again on the morning of October 6, 2004 when he was transferred from Kilby and out of my care.

It is my understanding that Mr. Nation contends he was not provided appropriate post-operative evaluation and/or treatment at Kilby. Based on my review of Mr. Nation's medical records, and on my personal knowledge of the treatment provided to him, however, it is my opinion that all of his medical conditions and complaints were evaluated and treated in a timely and appropriate fashion. At all times, myself and the other healthcare providers at Kilby exercised the same degree of care, skill, and diligence as other similarly situated health care providers would have exercised under the same or similar circumstances. In other words, it is my opinion that the appropriate standard of care was adhered to at all times in providing medical care, evaluation, and treatment to this inmate. In particular, Mr. Nation was provided appropriate medications and treatment for his medical conditions. At no time was he ever denied any medically necessary medication, treatment nor was he caused any injury or damages as a result of any denial of care, deficiency in care, or breach of the standard of care at Kilby.

At no time did I or any of the medical or nursing staff at Kilby Correctional Facility deny Mr. Nation any needed medical treatment, nor did we ever act with deliberate indifference to any serious medical need of Mr. Nation. Mr. Nation was seen and evaluated by the medical or nursing staff, and was referred to an appropriate care provider or given appropriate care, each time he registered any health complaints at Kilby Correctional Facility. At all times that he was at Kilby, Mr. Nation's medical complaints and conditions were addressed as promptly as possible under the circumstances."

Further affiant sayeth not.


MICHAEL E. ROBBINS, M.D.

STATE OF ALABAMA)

COUNTY OF)

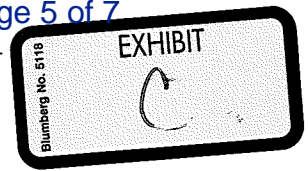
Montgomery)

Sworn to and subscribed before me on this the 13th day of Oct., 2006.

Betty J. Carr
Notary Public

My Commission Expires:

12-17-09



IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

MARVIN NATION, (AIS # 141669)

*

Plaintiff,

*

V.

*

2:06-cv-693-ID

WILLIE AMBERS, ET AL.

*

Defendants.

*

AFFIDAVIT OF LINDA LAWRENCE, R.N., H.S.A.

BEFORE ME, *Cynthia M. Butler*

, a notary public in and for said County and State, personally appeared **LINDA LAWRENCE, R.N., H.S.A.**, and being duly sworn, deposed and says on oath that the averments contained in the foregoing are true to the best of her ability, information, knowledge and belief, as follows:

“My name is Linda Lawrence. I am over the age of twenty-one and am personally familiar with all of the facts set forth in this Affidavit. I have been a licensed, registered nurse in Alabama since 1997. I hold an Associates Degree in nursing from Troy State University in Montgomery. I have worked as a nurse at Kilby Correctional Facility in Mt. Meigs, Alabama, since March of 2002, and have been the Health Services Administrator (H.S.A.) at Kilby since May of 2002. Since November 3, 2003, I have been employed by Prison Health Services, Inc., the company which currently contracts with the Alabama Department of Corrections to provide medical services to inmates.

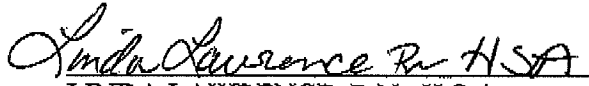
Prison Health Services, Inc. (PHS) has established a simple two-step procedure for identifying and addressing inmate grievances at Kilby Correctional Facility. If an inmate has a grievance regarding a healthcare issue he must submit to the healthcare unit an “Inmate Informal

Grievance" form. These are standard forms that may be acquired in the healthcare unit or from an inmate's supervising officer in his dormitory. The informal grievance allows an inmate to communicate any healthcare related concern by placing the form in the medical services complaint box or mailbox to be forwarded to the healthcare unit. I subsequently review the concern and respond via in house mail.

If the inmate is unsatisfied with my response, he may request an "Inmate Grievance Appeal" form from the healthcare unit. This form allows an inmate to again voice his concerns relating to the healthcare issue addressed with the informal grievance form. After the inmate has submitted the grievance appeal, I will meet with him face-to-face in a final attempt to address his concerns verbally.

It is my understanding that Marvin Nation has filed suit in this matter alleging that Dr. Robbins has failed to provide him with appropriate medical care subsequent to being involved in an automobile accident on September 21, 2004. However, Mr. Nation has failed to exhaust Kilby's informal grievance procedure relating to the receipt of medical care for this alleged condition. Specifically, as relevant to his Complaint, Mr. Nation has submitted neither an inmate informal grievance nor an inmate grievance appeal. As such, the healthcare unit at Kilby has not been afforded the opportunity to resolve Mr. Nation's medical complaints prior to filing suit."

Further affiant sayeth not.


LINDA LAWRENCE, R.N., H.S.A.

STATE OF ALABAMA)
)
COUNTY OF _____)

Sworn to and subscribed before me on this the 17th day of October, 2006.

Cynthia M. Butler
Notary Public

My Commission Expires:

12-15-2009